STATE OF ILLINOIS)
) SS
COUNTY OF LAKE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS,
ILLINOIS WORKERS' COMPENSATION COMMISSION
Petitioner,

14IWCC0291

vs.

NO. 11 INC 103

ALFRED ROTH, JR. individually, and as president of POTENTIAL TRAINING & WELLNESS, INC. a/k/a THE JUNGLE GYM, INC.,
Respondent,

DECISION AND OPINION RE: INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Division, brings this action, by and through the Office of the Illinois Attorney General, against the above captioned Respondent, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act ("the Act") and Section 7100.100 of the Rules Governing Practice Before the Industrial Workers' Compensation Commission ("the Rules"), codified as 50 Illinois Administrative Code, Chapter 11. Proper and timely notice was given to all parties.

A Hearing was held before Commissioner Michael J. Brennan on November 12, 2013 in Waukegan, Illinois. The Commission, after considering the record in its entirety and the applicable law, finds that Respondent Alfred Roth, Jr. individually, and as President of Potential Training & Wellness, Inc. a/k/a The Jungle Gym, Inc. willfully and knowingly violated Section 4(a) of the Act and Section 7100.100 of the Rules during the period of May 5, 2006 through November 14, 2007 and March 23, 2008 through August 1, 2009. As a result, the Respondent shall be held liable for this 1,056 day period and shall pay a fine pursuant to Sections 4(d) of the Act and 7100.100(b)(1) of the Rules at the rate of $250.00 per day, totaling $264,000.00, for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Alfred C. Roth, Jr. filed Articles of Incorporation for The Jungle Gym, II, Inc. with the Secretary of State on April 28, 2003. Mr. Roth, Jr. was listed as the registered agent and incorporator of The Jungle Gym, II, Inc. PX.4.

2. On November 25, 2005, Mr. Roth, Jr., as sole shareholder and sole director of The Jungle Gym, II, Inc., changed its name to Potential Training & Wellness Center, Inc. PX.4. Mr. Roth, Jr. was listed as the registered agent and owner of Potential Training & Wellness Center, Inc. *Id.*

3. According to the State of Illinois Department of Employment Security, Potential Training Wellness Center had wages in excess of $1,000.00 in 2007 and 2008. PX.5.

4. According to the Illinois quarterly withholding forms, Mr. Roth, Jr. reported compensation on behalf of Potential Training & Wellness Center from January 2006 through December 2008. PX.6.

5. On August 1, 2009, the Illinois Secretary of State dissolved Potential Training & Wellness Center, Inc. for failing to provide acceptable payment in connection with fees or taxes due as required by the provisions of The Business Corporation Act. The Business Corporation Act allows the Illinois Secretary of State to dissolve a corporation for the failure to provide acceptable payment in connection with fees or taxes due under the Act. PX.4.

6. On October 25, 2011, a Notice of Non-Compliance was mailed to Alfred Roth, Jr. The Notice was hand delivered to Mr. Roth, Jr. on October 28, 2011. PX.1. The Notice alleged non-compliance of Section 4(a) of the Act from May 5, 2006 to October 25, 2011. PX.1. The Notice required Mr. Roth, Jr. to submit evidence of compliance with the provisions of Section 4(a) of the Act or otherwise respond in writing to the Commission within thirty days of the date of receipt of the Notice. *Id.*

7. On June 21, 2012, a Notice of Insurance Compliance Hearing was hand delivered to Mr. Roth, Jr. PX.2. An Insurance Compliance Hearing was scheduled for September 18, 2012 at 9:00 a.m. in Waukegan, Illinois. PX.2

8. This matter was previously scheduled for hearing. The hearing was continued with the recommendation that Mr. Roth, Jr. obtain legal representation. This matter proceeded to hearing on November 12, 2013. Mr. Roth, Jr. appeared pro se and stated on the record that he chose to not obtain an attorney. T.5.

9. A notarized affidavit dated November 19, 2012 from the National Council on Compensation Insurance, Inc. (NCCI Holdings, Inc) was admitted into evidence. The affidavit was signed by Ms. Rhonda Garcia, Proof of Coverage Analyst for NCCI Holdings, Inc. The Illinois Workers' Compensation Commission has designated NCCI as its agent for the purpose of collecting proof of coverage

information on Illinois employers who have purchased workers' compensation insurance from carriers. The affidavit states that Alfred Roth, Jr. did not have workers' compensation insurance from May 5, 2006 to November 14, 2007 and from March 23, 2008 to the present. PX.3. Due to a scrivener's error, Petitioner's Exhibit 3 was inadvertently omitted from the record.

10. At hearing, Mr. Roth, Jr. testified that he did not have workers' compensation insurance from May 5, 2006 to November 14, 2007 and from March 23, 2008 to August 1, 2009. T.59.

11. Mr. Roth, Jr. presented Respondent's Exhibit 1 on his behalf. The exhibit was admitted into evidence without objection. According to the exhibit, Mr. Roth, Jr. stated that his insurance was cancelled on May 5, 2006. He further stated that he was unable to qualify for "Workman's Comp. Insurance" as one of the questions to qualify for insurance was whether "you ever had a previous claim b during the time of not being insured." RX.1.

12. An Arbitration Hearing was held on September 19, 2011 naming Potential Training & Wellness Center, Inc.; Alfred Roth, individually; Illinois State Treasurer and ex officio custodian of the Injured Workers' Benefit Fund. The Illinois Attorney General appeared on behalf of the Illinois State Treasurer and ex officio custodian of the Injured Workers' Benefit Fund. No appearance was made on behalf of Potential Training & Wellness Center, Inc. or Alfred Roth, Jr. The Arbitrator found that the Respondent was operating under and subject to Section 3(1) of the Act and an employee-employer relationship existed between Craig Jorgensen and Respondent as of May 23, 2007. The decedent died as a result of his injuries. He had two survivors. The Respondent was ordered to pay death benefits commencing May 27, 2007 of $430.69 per week to the surviving spouse, Betty Anne Jorgensen and on behalf of the children, Adam James Hough-Leifert until $500,000.00 has been paid or 25 years, whichever is greater, as provided in Section 7 of the Act. The Arbitrator further awarded burial expenses of $8,000.00 and medical expenses of $89,419.00. The award was entered against the Injured Workers' Benefit Fund to the extent permitted under Section 4(d) of the Act, in the event of the failure of the Respondent-employer to pay the benefits due and owing to petitioner. PX.7.

13. Respondent appealed to the Commission and a hearing was held on June 11, 2012. The Commission vacated the award of benefits under Section 7(a) to Adam James Hough-Leifert and affirmed and adopted the remainder of the Arbitrator's decision. PX.7.

14. The Illinois Attorney General's Office submitted a Proposed Decision and Opinion on December 10, 2013. They argue for the assessment of penalties in the amount of $250.00 per day for the period of 1,056 days for a total penalty of $264,000.00.

Pursuant to Section 3 of the Act, the provisions of this Act shall apply automatically to all employers engaged in any department of the following enterprises...: 17(a) any business...in which services are rendered to the public at large, provided that this paragraph shall not apply to such business or enterprise unless the annual payroll during the year next preceding the date of the injury shall be in excess of $1,000.00.

The Commission finds that Mr. Roth, Jr. operated Potential Training & Wellness Center, Inc. The business provided services to the public and had wages in excess of $1,000.00. Therefore, Mr. Roth, Jr. was operating under and subject to the provisions of Section 3 of the Act.

The Workers' Compensation Commission's authority and jurisdiction over insurance non-compliance cases is authorized by the Act, as well as the Rules. Under Section 4 of the Act, all employers who come within the auspices of the Act are required to provide workers' compensation insurance, whether this is done through being self-insured, through security, indemnity or bond, or through a purchased policy. Under Section 4(d):

> Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure of an employer to comply with any of the provisions of paragraph (a) of this Section . . . , the Commission may assess a civil penalty of up to $500 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. Each day of such failure or refusal shall constitute a separate offense. The minimum penalty under this Section shall be the sum of $10,000. Each day of such failure or refusal shall constitute a separate offense. The Commission may assess the civil penalty personally and individually against the corporate officers and directors of a corporate employer, the partners of an employer partnership, and the members of an employer limited liability company, after a finding of a knowing and willful refusal or failure of each such named corporate officer, director, partner, or member to comply with this section. The liability for the assessed penalty shall be against the named employer first, and if the named employer refuses to pay the penalty to the Commission within 30 days after the final order of the Commission, then the named corporate officers, directors, partners, or members who have been found to have knowingly and willfully refused or failed to comply with this Section shall be liable for the unpaid penalty or any unpaid portion of the penalty.

Section 7100.100 of the Rules codifies the language of the Act, and additionally describes the notice on noncompliance required, as well as the procedures of the Insurance Compliance Division, and how hearings are to be conducted. Reasonable and proper notice, as noted above, has been provided to the Mr. Roth, Jr. Section 7100.100(d)(3)(D) of the Rules indicates that "A certification from an employee of National Council on Compensation Insurance stating that no policy information page has been filed in accordance with Section 7100.30 shall be deemed prima facie evidence of

that fact." Petitioner's exhibit 3 establishes Mr. Roth, Jr. had no workers' compensation insurance from May 5, 2006 to November 14, 2007 and from March 23, 2008 to August 1, 2009, the date of dissolution of Potential Training & Wellness Center. Further, Mr. Roth, Jr. testified that he did not have workers' compensation insurance during the above period.

In *State of Illinois v. Murphy Container Service, et al.*, 2007 Ill.Wrk.Comp.LEXIS 1216, the Commission considered the following factors in assessing penalties against an uninsured employer: 1) the length of time the employer had been violating the Act; 2) the number of workers' compensation claims brought against the employer; 3) whether the employer had been made aware of his conduct in the past; 4) the number of employees working for the employer; 5) the employer's ability to secure and pay for workers' compensation coverage; 6) whether the employer had alleged mitigating circumstances; and, 7) the employer's ability to pay the assessed amount.

In the instant case, there is evidence that Mr. Roth, Jr. was aware of, and willfully ignored his statutory obligation to maintain workers' compensation insurance for a lengthy period of time. Mr. Roth, Jr. testified that he had worker's compensation insurance until May 5, 2006. His policy was then terminated for non-payment. No evidence was offered demonstrating that Mr. Roth, Jr. attempted to secure workers' compensation insurance. The Commission finds that Mr. Roth, Jr. knowingly and willfully failed to comply with the Act. The Commission further finds that the length of time in which Mr. Roth, Jr. had been violating the Act in failing to obtain workers' compensation coverage was significant.

In its Proposed Decision, the Attorney General's requests that the assessment of penalties in the amount of $250.00 per day for the period of 1,056 days be assessed against Mr. Roth, Jr. Having found that Mr. Roth, Jr. willfully and knowingly violated the Act, the Commission assesses penalties in the amount of $264,000.00 against Mr. Alfred Roth, Jr. individually, and as president of Potential Training & Wellness, Inc. a/k/a The Jungle Gym, Inc.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent Alfred Roth, Jr. individually, and as President of Potential Training & Wellness, Inc. a/k/a The Jungle Gym, Inc., found to be an employer who was in non-compliance with the insurance provisions of Section 4(a) of the Act and Section 7100.100 of the Commission Rules, is hereby ordered to pay the Commission a fine of $264,000.00 pursuant to Section 4(d) of the Act and Section 7100.100 of the Commission Rules.

Pursuant to Commission Rule 7100.100(f), once the Commission assesses a penalty against an employer in accordance with Section 4(d) of the Act, payment shall be made according to the following procedure: 1) payment of the penalty shall be made by certified check or money order made payable to the State of Illinois; 2) payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court of review after final adjudication to:

14IWCC0291

Illinois Workers' Compensation Commission
Fiscal Office
100 West Randolph Street Suite 8-328
Chicago, Illinois 60601
1-312/814-6625

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 23 2014

MJB/tdm
O: 4-8-14
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HEATHER WATSON,

Petitioner,

vs.

NO: 12 WC 21584

14IWCC0292

SILGAN CONTAINER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, and medical expenses both current and prospective, and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

In the second to last page of the Decision of the Arbitrator, there is a one sentence paragraph which is written: "There is no claim that the Petitioner's condition is related to any other accident." The Respondent has no duty to posit alternative theories on the causation of an alleged condition of ill being. It is Petitioner's burden to prove his or her case by a preponderance of the evidence. Therefore, the Commission strikes that sentence from the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 12, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:

APR 2 2 2014

Ruth W. White

Ruth W. White

Daniel R. Donohoo

Daniel R. Donohoo

Charles J. DeVriendt

Charles J. DeVriendt

RWW/dw
O-3/26/14
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

WATSON, HEATHER
Employee/Petitioner

Case# **12WC021584**

SILGAN CONTAINER
Employer/Respondent

14IWCC0292

On 4/12/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1937 TUGGLE SCHIRO & LICHTENBERGER PC
NICHOLAS M SCHIRO
510 N VERMILION ST
DANVILLE, IL 61832

0560 WIEDNER & MCAULIFFE LTD
MARY SABATINO
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0292

Heather Watson
Employee/Petitioner

v.

Silgan Container
Employer/Respondent

Case # 12 WC 21584

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana, Illinois**, on **March 21, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Should Respondent's Exhibit 6 be admitted into evidence**

FINDINGS

On the date of accident, **April 19, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $**41,600.00**; the average weekly wage was $**800.00**.

On the date of accident, Petitioner was **34** years of age, ***single*** with **2** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit for all bills paid by Petitioner's group insurance under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $533.33/week for 47 weeks, commencing April 27, 2012 through March 21, 2013, as provided in Section 8(b) of the Act.

The parties stipulated that all medical bills were paid by Petitioner's group health insurance. Respondent shall hold petitioner harmless from any claims for reimbursement from Petitioner's group health insurance carrier, as provided in Section 8(j) of the Act.

Respondent shall approve and pay for the L5-S1 anterior lumbar interbody fusion with posterior instrumented fusion recommended by Dr. Darwish and Dr. Rinella, as well as all reasonable and necessary follow up care, subject to the medical fee schedule.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

D. Dylan McCarthy
Signature of Arbitrator

April 9, 2013
Date

APR 12 2013

Heather Watson v. Silgan Container 12 WC 21584

Findings of Fact:

Petitioner testified that she began working for Respondent in approximately August of 2004. Her position was that of press operator. As a press operator, Petitioner was responsible for running a press that packages metal can ends. The can ends vary in size, from small to gallon size, and are packaged into "sleeves." Petitioner's job required her to manually load the sleeves onto pallets. During this process, Petitioner was required to bend and turn at the waist approximately one thousand times per day. This number was based on the number of sleeves on each pallet and how many pallets are processed each day. Petitioner explained that each pallet holds between 70 and 200 sleeves of metal can ends. She would process approximately five pallets per day when they held 200 sleeves and ten or eleven pallets when they held 70 sleeves. Petitioner estimated that 40 to 45 percent of the bending she did at work was full bends. She would have to bend to a lesser degree as the sleeves were stacked higher on the pallets. (Trans. pgs. 13-18).

Petitioner was on her feet for approximately seven hours per day at work after accounting for lunch and breaks. The floor surface was concrete. (Trans. pg. 19).

Petitioner testified that she does not do nearly as much bending and twisting outside of work. Her hobbies prior to April of 2012 included watching her children play sports, but did not include any activities that were stressful on her back. After beginning her employment with Respondent, Petitioner began to notice soreness and pain in her back over time. Petitioner estimated that these symptoms began in late 2010. The pain was not extreme at first, but became progressively worse over time. (Trans. pgs. 20-21).

Petitioner acknowledged that she had medical treatment for her back prior to April 19, 2012. She first sought treatment with Dr. Colbert and Melia McCord at Charlotte Ann Russell Medical Center. Her treatment consisted of spinal adjustments, physical therapy, and a cortisone shot. When her symptoms did not resolve, she was referred to Dr. Mickeala, who referred her to Dr. Santiago. Dr. Santiago then referred Petitioner to Dr. Darwish, who referred her to Dr. Rinella. (Trans. pgs. 21-22).

Petitioner acknowledged that on May 11, 2011, she irritated her back while helping her daughter up from a fall. Petitioner saw a doctor, who advised her to rest and use heat and ice. Petitioner testified that this incident caused a temporary flare up of back pain that lasted a couple of days. (Trans. pgs. 22-23).

Petitioner also testified that she went to the Emergency Department on October 3, 2011 when her sister fell on her. Petitioner explained that her sister fell on her chest, and that she did not injure her back in any way during this event. (Trans. pgs. 23-24).

Petitioner testified that none of the medical treatment she has undergone to date has provided lasting relief from her symptoms. The best relief she obtained was a couple of months following a nerve block done by Dr. Santiago. After the nerve block wore off, all of Petitioner's symptoms returned. (Trans. pgs. 24-25).

Petitioner testified that Dr. Darwish examined her on April 19, 2012. During that visit, Petitioner's MRI was reviewed, and Dr. Darwish asked her detailed questions about what she did at work. Dr. Darwish also asked Petitioner to demonstrate the mechanics of her job. Petitioner testified that this visit was the first time she came to believe her work may have been contributing to her back condition. (Trans. pgs. 25-26).

Petitioner testified that during the two years prior to April 19, 2012, bending and twisting, lifting, and laying flat on her back aggravated her back pain. Petitioner would rest after work during this time period. (Trans. pg. 27).

When Petitioner began working for Respondent, she was 5' 8" or 5' 9" tall and weighted about 115 pounds. She testified that she never had lower back pain or back problems prior to working for Respondent. She worked for Respondent for approximately six years before her back symptoms began. (Trans. pgs. 27-28).

Petitioner testified that she has been off work since April 27, 2012. On that date, she was given light duty restrictions that Respondent would not accommodate. She did not receive any temporary total disability compensation during that time period. (Trans. pgs. 28-29).

Petitioner's current symptoms include significant back pain, tingling down the back of her right leg into her foot, tingling down her left leg to a lesser extent, and trouble sleeping. Petitioner rated her pain as a 7 on a 10-point scale. That pain is present most of the time. (Trans. pgs. 30-31).

Petitioner testified that her medical bills have not been paid through workers' compensation. She indicated that some of her bills were paid by Blue Cross/Blue Shield, and requested a hold harmless. (Trans. pg. 30).

Petitioner testified that she wants to undergo the surgery recommended by Dr. Rinella so that she can reduce her pain and go back to work. (Trans. pg. 28).

On cross examination, Petitioner acknowledged that she may have been seen at the Hoopeston Community Memorial Hospital in October of 2002 for back pain that developed after lifting patients. Petitioner also testified that she was seen for low back pain in September of 2010 and that there was no specific event that brought on the pain. Petitioner also acknowledged seeing Dr. Colbert for back pain in October of 2010 and that she underwent spinal manipulations, therapy, and injections in the fall of 2010. She also sought treatment for her back at Robinson Chiropractic in March of 2011 and with Melia McCord, a physician's assistant, beginning in May of 2011. (Trans. pgs. 32-36).

Petitioner was on a leave of absence from work for her back condition from May 11, 2011 until July 22, 2011. During that time period, Petitioner underwent her first MRI. Petitioner acknowledged that she did not indicate her injury was not work related in a patient questionnaire she filled out when she first saw Dr. Santiago on June 20, 2011. (Trans. pgs. 38-39).

Petitioner testified that her back pain never completely resolved after it began in 2010. Activities of daily living aggravate Petitioner's back pain. (Trans. pg. 40).

The earliest medical record introduced into evidence was an Emergency Department note dated October 8, 2002. On that date, Petitioner presented to the Emergency Department at Hoopeston Community Memorial Hospital complaining of lower back pain. Petitioner gave a history of low back, left hip, and left leg pain after lifting patients at her job at a nursing home. She reported the pain has been present for around one month, but had gotten worse recently. Petitioner stated that her back does not hurt while lifting, but that it does after. She was diagnosed with a lumbosacral strain, was prescribed medication, and was discharged with instructions to use ice locally. (RX 9, pg. 14).

Petitioner presented to Keith Whitaker, PA-C at Charlotte Ann Russell Medical Center on September 13, 2010 complaining of back discomfort for the previous three weeks. She reported no history of injury. She

noted that her back pain is worse when she bends over. Physical exam showed tenderness in the paraspinal muscles bilaterally, a negative straight leg raise, and no evidence of scoliosis. An anti-inflammatory was prescribed, as was Flexeril. Petitioner was instructed to return to the clinic if she did not improve. (PX 1, pg. 46).

Petitioner returned to Charlotte Ann Russell Medical Center on October 4, 2010 to follow up on her low back pain and was evaluated by Dr. Jay Colbert. Petitioner related no history of injury but stated that she does tend to strain her back quite a bit a work. Petitioner reported little improvement in symptoms with the medications previously prescribed. Physical exam showed tenderness in the lower lumbar spine and the left sacroiliac joint. A spinal manipulation was performed and medications were continued. Petitioner was to follow up in a week if not significantly improved. (PX 1, pg. 44).

Petitioner returned to Dr. Colbert on October 12, 2010 for follow up. She reported ongoing pain in the lower back area. Physical exam was unchanged from the previous visit. A spinal manipulation was performed and medications were continued. Petitioner was to follow up in a week. (PX 1, pg. 43).

Petitioner returned to Dr. Colbert on October 19, 2010 complaining of continued low back pain. She was diagnosed with bilateral sacroiliitis. Injections to the SI joints were administered bilaterally. (PX 1, pg. 42).

Petitioner returned to Dr. Colbert on October 26, 2010. She reported one or two days of relief after the injections, but that her symptoms returned after she got back into her regular work routine. Petitioner was referred for physical therapy. (PX 1, pg. 41).

Petitioner began a course of physical therapy at Hoopeston Regional Health Center on October 28, 2010. Petitioner filled out an intake form in which she indicated her symptoms had been present for seven to sixteen weeks and that her condition was not being covered by workers' compensation. (RX 9, pg. 21). The initial therapy evaluation indicated Petitioner's pain level was a five to six out of ten and that bending and lifting, arising, and morning stiffness increased her pain. Petitioner was to undergo therapy for six weeks. (RX 9, pg. 18). Petitioner was discharged from therapy on December 8, 2010. It was noted that Petitioner had cancelled her appointment on November 16th and that she did not attend on November 19th or November 24th. The discharge report indicated that Petitioner's range of motion had improved, but that her pain was unchanged. (RX 9, pg. 19).

Petitioner returned to Dr. Colbert on November 22, 2010 complaining of persistent symptoms in her low back. An injection of the SI joint under fluoroscopy was recommended. Petitioner was to continue with medication and therapy until that could be arranged. (PX 1, pg. 39).

Petitioner presented to Robinson Chiropractic on March 1, 2011 for evaluation of low back pain. She gave a history of low back pain beginning in September of 2010. She reported doing a lot of lifting and bending with heavy objects but no specific incident of trauma. Petitioner stated that bending with her right foot forward. Petitioner noted that she had seen a doctor for manipulations and injections. She reported minor relief from the injections. Low back pain was noted to be sharp and piercing with radiation going into both hips. Pain in the low back was rated as a 3 to a 9. Petitioner also reported a dull ache in her mid and upper back, as well as her neck. It was noted that the neck symptoms began with a softball injury years ago. (PX 2, pg. 65). Treatment plan was for Petitioner to undergo spinal manipulation. (PX 2, pg. 68).

An x-ray of the lumbar spine performed March 1, 2011 showed spinal biomechanical alterations, degenerative disc disease at the L5 level, and facet tropism at L3-L4, L4-L5, and L5-S1. (PX 2, pg. 67).

Petitioner returned to Robinson Chiropractic from March 2, 2011 through March 11, 2011 for spinal manipulation. (PX 2, pgs. 72-73).

Petitioner returned to Charlotte Ann Russell Medical Center on May 4, 2011 complaining of low back pain that had been present for about six months. She was examined by Melia McCord, PA-C. Petitioner described the pain as a pinching sensation that is worsened by standing or bending over repetitively. She reported working in a factory and that she does experience pain during her shift. Dull aching in her joints was also reported, which Petitioner noted was very different from the pain she had in her back. It was noted that Petitioner had previously tried conservative treatment measures including muscle relaxers, pain medication, manipulation, and chiropractic treatment. Medications were prescribed for back pain, and an x-ray was recommended. (PX 1, pg. 33).

Petitioner returned to PA-C McCord on May 11, 2011 to follow up on her low back pain. Petitioner reported that her pain began long ago, but that it was recently aggravated while helping her daughter stand up. Petitioner's pain radiated into her buttocks bilaterally, but did not radiate into her thighs or lower extremities. Petitioner noted that the medication did not improve her pain. X-ray was reviewed, which was interpreted to show a relative disc space narrowing at L5-S1 and facet hypertrophy. Assessment was lumbago with evidence of L5-S1 disc space narrowing. Medrol Dosepak was prescribed and FMLA paperwork was completed. Petitioner was placed on light duty status. An MRI would be recommended if the Medrol Dosepak did not improve her pain. (PX 1, pg. 32).

An MRI performed on May 20, 2011 showed L5-S1 disc degeneration with a mild asymmetric right posterior disc bulge minimally encroaching on the right S1 nerve root sheath. (RX 10).

Petitioner presented to Dr. Alexander Michalow at Oak Orthopedics on June 17, 2011. She was referred by Dr. Colbert's office for evaluation of low back pain. Petitioner reported that the pain was chronic and had been present for more that a year. She reported no specific injury, but noted that her pain was worse with activity, especially bending, lifting, or twisting the spine. It was noted that Petitioner works in a factory and does very physical work. Petitioner reported only temporary partial relief in symptoms from her previous course of treatment. Physical exam showed tenderness in the paraspinal region, right side greater than left. Assessment was chronic back pain with minor disc bulge at L5-S1 with at least some pain related to work, which requires much physical lifting. Plan was for Petitioner to pursue pain management, as Dr. Michalow did not see a surgical lesion on the MRI. (PX 3, pgs. 107-108).

Petitioner presented to Dr. Juan Santiago-Palma at Oak Orthopedics on June 20, 2011 complaining of low back pain for the previous year. Petitioner described the pain as an aching sensation along the lower back without radiation into the lower extremities. Petitioner did not recall any specific precipitating event. She rated her pain as a 7 out of 10 in intensity and noted that her symptoms had been getting progressively worse. An MRI performed on May 20, 2011 was reviewed, which Dr. Santiago-Palma interpreted as showing disc degeneration at L5-S1 and a right posterior disc bulge with minimal encroachment upon the right S1 nerve root. Petitioner had not been working because of her symptoms. It was noted that Petitioner smokes 20 cigarettes per day. Physical exam revealed tenderness to palpation along the mid and lower paraspinals. Extension and right and left lateral rotation of the lumbar spine reproduced low back pain. Straight leg raise was negative. Clinical impression was lower back pain and lumbar degenerative disc disease. Treatment plan was for Petitioner to undergo facet joint injections along the right and left L3-L4, L4-L5, and L5-S1 facet joints. (PX 3, pgs. 120-121).

Dr. Santiago-Palma performed intraarticular lumbar facet joint injections at L3-L4, L4-L5, and L5-S1 on June 24, 2011. (PX 3, pgs. 90-91).

Petitioner returned to PA-C McCord on July 1, 2011. She reported that her back pain had improved after the facet joint injections. Petitioner still had pain with certain movements, such as bending, sitting too long, or lying down. She reported that she had been exercising daily and that she wanted to quit smoking. She was to continue to follow up with pain management. Petitioner was kept off work until her next appointment with Dr. Santiago. (PX 1, pg. 31).

Petitioner returned to Dr. Santiago-Palma on July 12, 2011 for follow up. She reported about 50 percent improvement in her symptoms for one week following the injections. She rated her pain as a 6 to 7 out of 10. Treatment plan was to proceed with an epidural steroid injection at L5-S1. (PX 3, pgs. 122-123).

Dr. Santiago-Palma performed an epidural steroid injection at L5-S1 on July 26, 2011. (PX 3, pgs. 92-93).

Petitioner returned to Dr. Santiago-Palma on August 11, 2011 and reported significant relief of symptoms from the epidural injection. She rated her pain as a 1 out of 10. A home exercise program was recommended, and Petitioner was to return in two months. (PX 3, pgs. 124-125).

Petitioner returned to Dr. Santiago-Palma on October 11, 2011. Her low back pain had returned. She rated her pain as a 7 out of 10. Treatment plan was to perform another epidural injection at L5-S1. (PX 3, pgs. 133-134) A questionnaire Petitioner completed indicated that she was working in her regular job but felt unable to work due to her symptoms. (PX 3, pgs. 128-129). Petitioner was given work restrictions of no lifting over 10 pounds. (PX 3, pg. 135).

Dr. Santiago-Palma performed another epidural steroid injection at L5-S1 on October 14, 2011. (PX 3, pgs. 94-95).

Petitioner returned to Dr. Santiago-Palma on November 4, 2011 and reported significant relief of symptoms from the epidural injection. She rated her pain as a 1 out of 10. She was to continue her home exercise program and follow up in two months. (PX 3, pg. 136).

Petitioner returned to Dr. Santiago-Palma on December 19, 2011. Her low back pain had again returned, and was rated as a 7 out of 10 in intensity. Petitioner had obtained only temporary relief from the epidural injections. Treatment plan was for Petitioner to undergo median branch blocks along the bilateral L2-L3, L3-L4, L4-L5, and L5-S1 facet joints. If this provided significant relief, radiofrequency ablation would be considered. (PX 3, pgs. 146-147).

Dr. Santiago-Palma performed a diagnostic median branch block of the lumbar facet joints on January 3, 2012. (PX 3, pgs. 96-97),

Petitioner returned to Dr. Santiago-Palma on January 5, 2012 and reported about 70 percent improvement in her symptoms during the anesthetic phase of the median branch blocks. Treatment plan was to proceed with radiofrequency ablation. (PX 3, pgs. 148-149).

Dr. Santiago-Palma performed a radiofrequency median branch facet neurotomy on January 11, 2012. (PX 3, pgs. 98-99).

Petitioner returned to Dr. Santiago-Palma on January 19, 2012, complaining of worsening pain along the left side of her lower back along the sacroiliac joint region. Treatment plan was physical modalities for the pain

and Tylenol as needed. She was to follow up in two weeks. She was allowed to return to work without restrictions. (PX 3, pgs. 150-151).

Petitioner returned to Dr. Santiago-Palma on February 2, 2012 and reported that all her symptoms had resolved. She rated her pain as a 0 out of 10. She was to continue home exercises and was to follow up as needed. (PX 3, pg. 152).

Petitioner returned to Dr. Santiago-Palma on March 30, 2012 complaining of worsening low back pain radiating into the right lower extremity. Petitioner also reported numbness along the posterior aspect of the right side. Treatment plan was for Petitioner to undergo another epidural injection at L5-S1. (PX 3, pgs. 161-162).

Dr. Santiago-Palma performed another epidural steroid injection at L5-S1 on April 3, 2012. (PX 3, pgs. 100-101).

Petitioner presented to Dr. Ashraf Darwish at Oak Orthopedics on April 5, 2012. Dr. Michalow referred her to Dr. Darwish. Petitioner complained of low back pain radiating into her right buttock and right posterior thigh, which had been getting progressively worse for the last year. Petitioner described her job as a manual labor position in which she is required to bend over and lift objects weighing approximately 17 pounds continuously for eight hours per day. She reported working in that capacity for the last ten years. Petitioner rated her pain as a 7 out of 10 in her leg and a 8-9 out of 10 in her low back. Sitting, lying down, arising from a chair, and physical activity, aggravates her pain. Physical exam revealed a positive sitting root test on the right side, reproducing pain in the right buttock and posterior thigh. Lying root test was positive on the right side and negative on the left. X-rays were reviewed, which showed loss of normal lumbar lordosis and mild loss of disc height at L5-S1. An updated MRI was recommended because Petitioner's last MRI was over a year ago and her symptoms had become progressively worse since that time. Work restrictions were given, which included no sleeving or running the press, no lifting more than 10 pounds, no repetitive motion, minimum bending, stooping, twisting and squatting. (PX 3, pgs. 167-169).

An MRI performed on April 16, 2012 showed L5-S1 circumferential annular disc bulging, right paramedian/pre-foraminal disc extrusion impinging the right S1 nerve root, and minor degenerative disc disease. (PX 3, pg. 104).

Petitioner returned to Dr. Santiago-Palma on April 17, 2012 and reported about 50 percent improvement in her symptoms after the most recent injection. She rated her pain as a 2 out of 10. An MRI performed on April 16, 2012 was reviewed, which Dr. Santiago-Palma interpreted to show circumferential disc bulging at L5-S1 as well as degenerative changes. Dr. Santiago-Palma advised Petitioner to follow up with Dr. Darwish. She was to follow up with Dr. Santiago-Palma on a p.r.n. basis. (PX 3, pg. 170).

Petitioner returned to Dr. Darwish on April 19, 2012 complaining of ongoing low back pain and right lower extremity radiculopathy. Petitioner stated that her back pain is worse than her right lower extremity radiculopathy and that it was preventing her from being active. Petitioner's pain was worse with activity, especially when lifting things off the ground at work. The recent MRI was reviewed, which Dr. Darwish interpreted as showing L5-S1 disc desiccation with mild decrease in disc height. A circumferential annular disc bulge with right paramedian disc herniation causing impingement on the right S1 nerve root was present. Assessment was lumbar spondylosis without myelopathy and L5-S1 degenerative disc disease with a right paramedian disc protrusion causing right-sided neuroforaminal stenosis. Dr. Darwish discussed surgical and non-surgical interventions with Petitioner. He believed Petitioner should continue weighing her options before deciding on a lumbar fusion, due to her young age. Dr. Darwish stated that he believes the reason Petitioner had degenerative disc disease at such a young age is due to the repetitive lifting that she has been doing at work for

quite a while. Petitioner was to try not to lift anything off the ground over 20 pounds. She was to continue seeing Dr. Santiago for conservative management. If her symptoms did not improve, a lumbar fusion would be considered. (PX 3, pgs. 171-172).

A work status report from Dr. Darwish dated April 19, 2012 indicated that Petitioner's injury was the result of her job, which is bending and lifting all the time. Work restrictions were given, which included no sleeving or running the press, no lifting from floor up, no repetitive motion, minimum bending, stooping, twisting and squatting. (PX 3, pg. 173).

Petitioner returned to Dr. Santiago-Palma on June 7, 2012 complaining of pain in her low back and right lower extremity, as well as numbness along the posterior aspect of her right thigh. She rated her pain as a 7 out of 10. She reported using Mobic, which provided some relief of her symptoms. Treatment plan was for Petitioner to undergo a right transforaminal epidural steroid injection at L5-S1. (PX 3, pgs. 182-183).

Dr. Santiago-Palma performed a right transforaminal epidural steroid injection at L5-S1 on June 13, 2012. (PX 3, pgs. 102-103).

Petitioner returned to Dr. Darwish on June 26, 2012, complaining of continued low back pain and right lower extremity radiculopathy that had not improved with conservative management. Petitioner reported that she was currently unable to work due to the pain in her low back and right lower extremity. Petitioner stated that she was unable to live with the type of pain she had. Dr. Darwish had a long discussion with Petitioner regarding treatment options. Petitioner advised that she wished to proceed with surgical intervention. She was to be scheduled for an L5-S1 anterior lumbar interbody fusion with posterior instrumented fusion. Because of a past hysterectomy, Petitioner was to see Dr. Lang, an exposure surgeon, for evaluation. If Dr. Lang was able to provide exposure for the fusion procedure, then Dr. Darwish would proceed with surgery. (PX 3, pgs. 184-185).

Petitioner returned to Dr. Santiago-Palma on July 3, 2012 for follow up. Dr. Santiago-Palma indicated that Petitioner had exhausted conservative care and she should follow up with Dr. Darwish. (PX 3, pgs. 186-187).

Petitioner presented to Dr. Anthony Rinella at the Illinois Spine and Scoliosis Center on July 12, 2012, complaining of tenderness in her back extending into her right buttock. Petitioner reported that the pain began in late 2009. Dr. Rinella reviewed the MRI performed on April 16, 2012 and interpreted it as showing disc desiccation at L5-S1 and a right-sided disc herniation at L5-S1. Dr. Rinella concurred with the surgical recommendation of Dr. Darwish and indicated he would be willing to perform the procedure. (PX 5, pgs. 212-213).

Dr. Robert Bernardi examined Petitioner at the request of Respondent on October 23, 2012. Petitioner provided a history of low back pain beginning in September of 2010. She indicated that her low back pain was not the result of any specific incident and that she attributed her symptoms to the repetitive nature of her work. Petitioner described her work as involving feeding pieces of metal into a press, which would emerge as circular can ends. She would then load the can ends into a sleeve and would place the full sleeves on a pallet. She described the sleeves as weighing between 11 and 17 pounds. When the factory was busy, it was not unusual for Petitioner's back to get sore during a workday. Petitioner reported that her pain was isolated to her lower back at first, but began radiating into her right buttock over time. She had also developed pain that radiated into the right leg. She described her symptoms as constant. Dr. Bernardi reviewed Petitioner's medical records and imaging studies. Dr. Bernardi also performed a physical examination, which revealed reduced extension of the lumbar spine, approximately 50 percent of normal. Range of motion of the right hip produced right buttock

pain. Straight leg raising on the left and right produced right buttock pain. Diagnosis was L5-S1 degenerative disc disease and right L5 radiculopathy. (RX 1).

Dr. Bernardi opined that Petitioner's back symptoms were not caused by her work activities on or about April 19, 2012. Dr. Bernardi offered two reasons for his opinion. First, the Petitioner had had a chronic history of back pain predating April of 2012, which was documented in her medical records. Second, there was nothing in Petitioner's medical records to suggest that there was any event at work on April 19, 2012 that might have caused, altered, or in any way exacerbated her pre-existing problem. Dr. Bernardi noted that recent research indicated that the role of occupational and recreational activities on the development and progression of degenerative disc disease is minimal, with the primary factor being genetic factors. Dr. Bernardi believed that Petitioner's pain was due to her L5-S1 degenerative disc disease and not the disc bulge at L5-S1. He disagreed with the radiologist's interpretation of the MRI performed on April 16, 2012. Dr. Bernardi felt that test showed degenerative findings, and disagreed with the radiologist's use of the term "disc extrusion," which he felt implied an acute abnormality. Dr. Bernardi reviewed the MRI report dated May 20, 2011 and noted the report described the same findings as were present in the MRI performed on April 16, 2012. Dr. Bernardi opined that because the findings at L5-S1 were present in May of 2011, they could not have been caused by any work activity that occurred on April 19, 2012. Dr. Bernardi agreed with the surgery recommended by Dr. Rinella. (RX 1).

Dr. Bernardi was deposed on November 16, 2012. Dr. Bernardi testified that he is a board certified neurosurgeon. He explained that a neurosurgeon differs from an orthopedic surgeon in that a neurosurgeon devotes a higher portion of his practice to spinal surgery. (RX 2, pgs. 5-7). Dr. Bernardi's diagnosis of Petitioner based on his examination as well as his review of the medical records was L5-S1 degenerative disc disease and right L5 radiculopathy. He opined that neither of his diagnoses were related to any work accident or work activities that may have manifested on April 19, 2012. Dr. Bernardi offered three reasons for his opinion. First, Petitioner had a documented history of back problems prior to April 19, 2012. Second, he interpreted Petitioner's imaging studies to show results that were entirely degenerative in nature. Third, Dr. Bernardi felt there was no significant change in Petitioner's condition after April 19, 2012. (RX 2, pgs. 14-16). Dr. Bernardi discussed a recent study that followed identical twins and ultimately found that the development of degenerative disc disease is almost entirely determined by genetic factors. That study concluded that the role of occupational activities was minimal and that application of loads to the spine on a repetitive basis does not adversely affect disc physiology. (RX 2, pgs. 16-18). Dr. Bernardi was asked to assume that Petitioner lifted 11 to 17 pounds at work on a repetitive basis and whether he believed that activity would aggravate degenerative disc disease. Dr. Bernardi opined that it would not, because the science on the subject does not suggest that life activities aggravate the process. (RX 2, pg. 19). Dr. Bernardi also opined that Petitioner's work activities did not cause the L5-S1 disc herniation diagnosed by her treating physicians. Dr. Bernardi disagreed that the MRI performed on April 16, 2012 showed a disc protrusion at L5-S1. He felt it showed a degenerative disc bulge. Additionally, Dr. Bernardi felt that the prior MRI performed on May 20, 2011 documented the same degenerative disc bulge and that it could not have laid dormant for over a year before causing leg pain. Dr. Bernardi opined that Petitioner's symptoms were not consistent with an L5-S1 disc extrusion, as that would cause pain straight down the back of the leg and calf. Petitioner's pain was more consistent with L5 disease. (RX 2, pgs. 22-24).

On cross examination, Dr. Bernardi testified that Petitioner's symptoms correlated with his physical exam findings as well as the findings on the MRI film he reviewed. Petitioner exhibited no signs of symptom magnification during her examination, and Dr. Bernardi felt she was very credible. Dr. Bernardi agreed that Petitioner was a candidate for the surgery proposed by Dr. Rinella. (RX 2, pgs. 25-26). Dr. Bernardi testified that exercise appears to have a beneficial effect on the lumbar discs, but acknowledged that exercise as most people do it is different than repetitive bending and twisting in an industrial environment. Dr. Bernardi was unaware of any studies showing a correlation between repetitive bending and twisting and the progression of

degenerative disc disease. Dr. Bernardi testified that if such studies exist, it could have an effect on his causation opinion if they were good studies. (RX 2, pgs. 29-30). Dr. Bernardi testified that he does not believe repetitive bending and twisting of the spine ever causes an acceleration of degenerative disc disease. (RX 2, pgs. 30-31). Dr. Bernardi did not know how many sleeves Petitioner loaded onto pallets each hour, or even each day. He also did not know the height of the machine from which Petitioner picked up the pallets or the height of the pallet on which she stacked them. (RX 2, pg. 32). Dr. Bernardi testified that he did not review the film of the MRI performed on May 20, 2011. He explained that without reviewing the film, he could not state, to within a reasonable degree of medical certainty, that the disc bulge at L5-S1 did not worsen between May 20, 2011 and April 16, 2012, the date of the most recent MRI. (RX 2, pgs. 35-36). Dr. Bernardi testified that his overall opinion is that the primary factor that influences the progression of degenerative disc disease is genetics, and that environmental factors such as repetitive work are only minor factors. He testified that Petitioner's job as she described it to him could be a small factor in the progression of her degenerative disc disease. (RX 2, pg. 38).

On re-direct, Dr. Bernardi clarified that while he felt Petitioner's work activities could be a small factor in the progression of her degenerative disc disease, he could not state that to within a reasonable degree of medical certainty. (RX 2, pg. 39).

Dr. Ashraf Darwish was deposed on February 8, 2013. Dr. Darwish is an orthopedic spine surgeon. His practice is essentially only spine surgery, as Dr. Darwish does not perform any other type of surgical procedures. He only treats patients with neck and back pain. (PX 6, pgs. 4-5). Dr. Darwish is board eligible, meaning he has passed his board examination, but still has to collect surgical cases for two years and submit them to the orthopedic board. After defending his cases in front of the board, he will become board certified. (PX 6, pg. 7). Dr. Darwish has performed between 150 and 200 spine surgeries within the past year. (PX 6, pg. 8).

Dr. Darwish testified that he sees patients who have lower back injuries and pain due to repetitive motion. (PX 6, pg. 9). He estimated that approximately 20 percent of his practice is treating patients with degenerative disc disease causing low back or lower extremity pain. (PX 6, pg. 11). Dr. Darwish first examined Petitioner on April 5, 2012. He took a history from Petitioner in which she indicated her job required her to repetitively bend over, grab an item weighing approximately 20 pounds, and move the item to another position. She did this over and over for eight hours per day, five days per week. (PX 6, pgs. 12-13). Dr. Darwish testified that Petitioner had findings consistent with degenerative changes or a herniated lumbar disc at the time of his first examination. He recommended initially that Petitioner continue with conservative management and obtain a new MRI. (PX 6, pg. 14). Dr. Darwish next examined Petitioner on April 19, 2012. The MRI obtained April 16, 2012 showed degenerative disc disease at the L5-S1 level with a disc protrusion or herniation on the right side compressing the right S1 nerve root. (PX 6, pg. 15). Dr. Darwish opined that Petitioner's repetitive work activities were a causative factor in the development of her lumbar spondylosis without myelopathy as well as her degenerative disc disease and disc herniation at L5-S1. (PX 6, pgs. 16-17). When Dr. Darwish examined Petitioner on June 26, 2012, her symptoms had worsened, and her pain was not well controlled with medication or injections. At that time, Dr. Darwish recommended proceeding with an anterior lumbar interbody fusion with a posterior instrumented fusion. (PX 6, pg. 20). Dr. Darwish opined that Petitioner's pain would likely worsen without surgery, and that continuing in her job with Respondent would also worsen her symptoms. (PX 6, pgs. 21-22). Dr. Darwish believed Petitioner could return to her regular employment within six to twelve months following surgery if a successful fusion was obtained. (PX 6, pgs. 34-35).

On cross examination, Dr. Darwish testified that he did not review the actual film of the MRI performed on May 20, 2011. Without reviewing the actual film, he could not say for certain whether there was any progression or changes between the May 20, 2011 MRI and the MRI performed on April 16, 2012. (PX 6, pgs. 23-24). Dr. Darwish testified that Petitioner told him that the weight of the objects she lifted at work varied, but

he did not know how much. He also did not know how many objects she lifted per hour, or where she had to place the objects. Dr. Darwish's understanding was that Petitioner was moving the objects all day, other than during lunch and breaks. (PX 6, pgs. 25-26). Dr. Darwish agreed that there are a number of things that can contribute to the development of degenerative disc disease. He also agreed that there was no way to date the disc herniation seen on Petitioner's MRI tests and that it could have been present for years. Dr. Darwish opined that it was unlikely that Petitioner's disc herniation and degenerative disc disease was the result of normal wear and tear, due to her young age. He explained that it is unlikely for a person in their 30s to have such advanced degenerative disc disease. (PX 6, pgs. 26-27). Dr. Darwish was unaware of any studies showing that degenerative disc disease is a genetic disease. (PX 6, pg. 28). Dr. Darwish testified that it would not be unreasonable to perform a fusion surgery on Petitioner, even though she is a smoker. He expected Petitioner would quit smoking prior to the operation, which was his recommendation. (PX 6, pgs. 35-36).

Conclusions of Law:

The Petitioner is claiming a repetitive trauma injury involving her lower back. Such an injury is considered "accidental" even though it develops gradually over a period of time if it is caused by the performance of one's job. See Cassens Transport Company, Inc. v. The Industrial Commission, 262 Ill. App. 3d 324 (1994) Petitioner must prove the injury was work related and not the result of normal aging. As stated below, the Arbitrator believes the Petitioner, a 35 year old female who worked for eight years in a job requiring repetitive lifting throughout the course of a normal work day, has met her burden of proof. The more interesting issue is whether the Petitioner has chosen a proper date of accident. The Arbitrator believes that she has.

There is no question that the Petitioner had lower back symptoms which she thought were job related prior to April 19, 2012. From October 4, 2010, she referred to her work duties in connection with her lower back treatments which she received from her various providers. There is also no question that she continued to perform her regular job for much of that time, and noticed an increase in her symptoms. When she was referred to Dr. Darwish by Dr. Santiago on March 30, 2012, she reported that her lower back pain had increased, and now extended down her right leg. (PX 4)

It wasn't until she was seen by Dr. Darwish, however, that she became aware of her condition. On April 5, her first visit, she discussed in detail her job duties with the doctor. On her second visit with Dr. Darwish on April 19, 2012, after her second MRI, she learned that she had right forminal stenosis at L5-S1 related to a degenerative disc. (PX 4, 4-19-12)

The proper date of accident due to repetitive trauma is the date when a reasonable person knows about her injury and its causal relationship to work. While the Petitioner knew that she had a problem related to her job prior to April 19, 2012, she didn't know what the problem was; i.e. her injury, until discussing it with Dr. Darwish on that date.

This case presents a fact pattern similar to that seen in the case of Durand v. The Industrial Commission, 224 Ill. 2d 53 (2006). There the petitioner had carpal tunnel symptoms in 1997 and told her supervisor in 1998 that she thought her problem was work related. As in the instant case, she kept doing her regular job and didn't learn of the diagnosis until electrical studies were performed on September 8, 2000. She chose that date as her date of accident. The Court reversed the Appellate Court's finding that the claim was time barred. They referred to the 1988 decision in Oscar Meyer to support their position. They said that it would be unfair to punish the petitioner by barring her claim because she chose to try and work through her problem as long as she could. The Court went on to say that the date of accident in a repetitive trauma case should be determined by using a flexible standard. There, as here, the date of accident could certainly be the date the Petitioner learned of her diagnosis.

The Arbitrator also finds that Petitioner's current condition of ill-being is causally related to the accident of April 19, 2012. Two conflicting medical opinions were offered into evidence. The doctors, who testified by way of deposition, had basically the same understanding as to Petitioner's job duties while she worked for the Respondent from 2004 through April 27, 2012. Dr. Darwish's office note of April 5, 2012 states that the Petitioner had worked ten years bending, lifting and twisting with objects weighing approximately 17 pounds over an eight hour shift. (PX 4) He gave basically the same testimony. (PX 6 at 13) Dr. Bernardi testified that the Petitioner lifted sleeves full of can lids weighing 11 to 17 pounds over the course of a normal work day. (RX 2 at 15)

Dr. Darwish opined that her repetitive work activities were a causative factor in the development of her lumbar spondylosis without myelopathy as well as her degenerative disc disease and disc herniation at L5-S1. He elaborated that it is unlikely that an individual of the Petitioner's age would have such advanced degenerative disc disease due to normal wear and tear. (PX 6 at 15,27)

Dr. Bernardi, on the other hand, did not believe Petitioner's low back condition was caused by her employment. Dr. Bernardi testified that he does not believe repetitive bending and twisting of the spine ever causes an acceleration of degenerative disc disease. However, Dr. Bernardi also testified that Petitioner's job as she described it to him could be a small factor in the progression of her degenerative disc disease. (RX 2 at 19, 38)

There is no claim or opinion that the Petitioner's condition is related to any other accident.

The Arbitrator adopts the opinion of Dr. Darwish. Dr. Darwish unequivocally testified that Petitioner's repetitive work activities were a causative factor in the development of her low back conditions. A work-related injury need not be the sole or principal causative factor, as long as it was a causative factor in the resulting condition of ill-being. Sisbro v. Industrial Comm'n, 207 Ill.2d 193 (2003). Even Dr. Bernardi acknowledged that Petitioner's work activities could be a contributing factor in the progression of her degenerative disc disease. Accordingly, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the accident of April 19, 2012.

The parties stipulated that all medical bills were paid by Petitioner's group health insurance. Respondent shall hold petitioner harmless from any claims for reimbursement from Petitioner's group health insurance carrier, as provided in Section 8(j) of the Act.

The Arbitrator finds that Petitioner is entitled to prospective medical care. Both Dr. Darwish and Dr. Rinella have proposed an anterior lumbar interbody fusion with a posterior instrumented fusion. Dr. Bernardi agreed that this procedure is reasonable and necessary to treat Petitioner's low back condition. Respondent is ordered to approve and pay for the surgery proposed by Dr. Darwish and Dr. Rinella, subject to the medical fee schedule.

Petitioner is awarded temporary total disability compensation benefits from April 27, 2012 through March 21, 2013, representing 47 weeks. Respondent stipulated that Petitioner was temporarily totally disabled during this time period, but denied liability for temporary total disability benefits. Based on the Arbitrator's findings with regard to accident and causal connection, petitioner is awarded temporary total disability benefits for the stipulated time period. Temporary total disability benefits are to continue as long as Petitioner meets the statutory requirements for those benefits.

The Arbitrator declines to impose penalties or attorney's fees on Respondent, due to the disputes regarding accident and causal connection. Although Petitioner has met her burden of proof regarding accident and causation, the Arbitrator cannot say that Respondent's defense of this claim was unreasonable and vexatious. Respondent relied on the opinion of Dr. Bernardi, and that reliance was not unreasonable.

The Arbitrator will allow Respondent's Exhibit 6, its updated response to penalties, into evidence. In the exhibit, the Respondent added to an earlier response the testimony of Dr. Bernardi, which was provided at a deposition which the Petitioner's attorney participated in. Certainly the Petitioner could not claim any surprise in the contents of the exhibit. It may have been filed late, but the Respondent's attorney contended that she did not receive a file stamped copy of the Petition for Penalties, which by rule would start the time in which her response had to be filed.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Causal Connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nathanial Hollis,

Petitioner,

vs.

NO: 12 WC 13618

14IWCC0293

United Airlines, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, prospective medical treatment and temporary total disability and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of causal connection as stated below and remands this case to the Arbitrator for further proceedings for a determination of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner, a 44-year-old ramp serviceman, filed an Application for Adjustment of Claim alleging injuries to his left knee and groin occurring in the course of and arising out of his employment by Respondent on March 12, 2012. While kneeling inside the baggage hold of an aircraft, Petitioner was struck at his left knee and groin by some dislodged and falling baggage. (T. 13-18) Petitioner testified that he did not immediately realize that he sustained an injury, but approximately twenty-five minutes later when he attempted to stand he felt pain in his left knee and groin. (T. 19-21) He was able to continue working and did not seek immediate medical treatment. (T. 21) The following day, Petitioner was examined at Concentra Medical Center, where he was referred for a course of physical therapy for his left knee and issued light duty work restrictions. (PX 1) Petitioner's injury was subsequently evaluated by his primary care physician, Dr. Zapata. (PX 2) On referral from Dr. Zapata, Petitioner began treating with Dr. Nam at Chicago Orthopaedics and Sports Medicine. (PX 4) Dr. Nam recommended an

exploratory arthroscopic surgery with a partial medial meniscectomy and a potential microfracture of the medial femoral condyle depending on the arthroscopic findings. Prior to surgery, Dr. Nam cautioned that Petitioner's arthritic symptoms would not be alleviated by the arthroscopic surgery. Respondent authorized the treatment and Dr. Nam performed the surgery on June 23, 2012. (PX 4)

Petitioner continued to complain to Dr. Nam of severe pain and functional limitations, although the physical therapy records show that Petitioner progressed to full performance of the exercises with minimal complaints of pain. However, Dr. Nam found that Petitioner was a candidate for an osteochondral graft procedure or a total knee replacement based on the extent of his arthritis and his subjective symptoms. (PX 4) Petitioner sought authorization for treatment from Respondent and was examined by Dr. D'Silva pursuant to §12 on December 17, 2012. Dr. D'Silva opined that a total knee replacement was reasonably necessary treatment but that the advanced arthritic condition of Petitioner's left knee is unrelated to the work injury sustained on March 12, 2012. Dr. D'Silva opined that advanced avascular necrosis and osteoarthritis of the medial femoral condyle is not caused by acute injury. Dr. D'Silva furthermore doubted that any arthroscopic findings from the initial surgery on June 23, 2012 were post-traumatic in nature. In reviewing Dr. Nam's records and the operative report, Dr. D'Silva noted that the suspected subchondral impaction fracture did not exist. The operative findings were chondral fraying of the patellofemoral joint, large medial plica, grade two medial femoral condyle wear, a complex tear of the posterior horn and body of the medial meniscus, a tear in the body of the lateral meniscus and unstable chondral flaps of the lateral tibial plateau with superficial areas of underlying exposed bone. The only medical opinion interpreting the operative report with respect to causal connection is from Dr. D'Silva. Dr. D'Silva's opinion that a total knee replacement was medically necessary but unrelated to the accident is not rebutted. (RX 1) Respondent declined to authorize the surgery and disputed liability based on the opinion of Dr. D'Silva.

At the 19(b) hearing on May 16, 2013, Petitioner was still off of work recovering from his February 5, 2013 total knee replacement. On direct examination, Petitioner denied any left knee injuries prior to March 12, 2012 and denied any prior complaints of pain in the left knee or any symptoms such as he experienced after the accident. (T. 11-12; 22) On cross examination, Petitioner denied receiving a settlement in a prior workers' compensation case that included compensation for injuries sustained to his left knee. (T. 48) Petitioner was confronted with the settlement contract apportioning permanent partial disability for injuries sustained to the left and right legs as a result of a fall sustained on August 1, 2003. (T. 50; RX 9) Petitioner denied any knowledge that the 2005 settlement with Respondent encompassed the left knee. (T. 51) Petitioner was shown a treatment record from Dr. Treister dated November 3, 2004 that indicated an increase in left knee symptoms following right knee surgery. Petitioner then asked the Arbitrator for time to speak with his counsel before any further questioning. (T. 51-54) During continued cross-examination Petitioner admitted that prior to March 12, 2012 his left knee had in fact been symptomatic. (T. 55) On redirect examination, Petitioner testified that to the best of his recollection however, there could be no medical records relating to left knee symptoms or treatment since November 3, 2004. (T. 64-66)

Records submitted into evidence by Respondent include the radiologist's report of a left knee x-ray performed just two weeks prior to the March 12, 2012 accident. On February 27,

2012, the left knee x-ray, ordered by Dr. Zapata for the purpose of evaluating Petitioner's left knee pain, revealed degenerative joint disease and osteoarthritis, with narrowing of the medial compartment and an osteophyte at the patella. (RX 4)

In a June 25, 2013 Decision, the Arbitrator awarded the requested medical treatment and temporary total disability benefits. The Arbitrator found that while Petitioner had a left knee x-ray only two weeks prior to the accident, the totality of the evidence indicated only minor pre-existing complaints. The Arbitrator noted that Petitioner was able to perform his regular duties until the date of accident. However, the Arbitrator noted the lack of a causal connection opinion from Petitioner's surgeon with respect to the need for a total knee replacement. Dr. Nam was not deposed, and following the June 23, 2012 arthroscopy Dr. Nam's records are silent on causation. Nevertheless, the Arbitrator found that Petitioner proved the March 12, 2012 accident was at least a contributing cause in the exacerbation of Petitioner's preexisting conditioning and was therefore causally related to his need for a total knee replacement. We disagree.

The September 18, 2012 MRI arthrogram performed in advance of the total knee replacement, revealed advanced degenerative joint disease and osteoarthritis: "tricompartmental osteoarthritis, near complete cartilage loss at the weight-bearing portion of the medial compartment, dense sclerosis of the subchondral bone with surrounding edema in the medial femoral condyle and serpentine linear area immediately adjacent to the subchondral bone plate highly suspicious for focal subchondral osteonecrosis." Dr. Nam counseled Petitioner that he may not have a lasting result from an osteochondral graft, due to the size of his osteochondral lesion, and may require a total knee replacement for definitive treatment. (PX 4) Petitioner decided to pursue the total knee replacement because he knew that his knee was "steadily deteriorating." (T. 66) Following the February 5, 2013 total knee replacement, once again only Dr. D'Silva analyzed the surgical findings from a causal connection perspective. Dr. D'Silva found no evidence in operative report indicating that the condition of Petitioner's left knee was secondary to the accident. (RX 2)

Even when it is undisputed that an accident causes a claimant's condition to become symptomatic, or more severely so, it is not necessarily true that any condition subsequent to the accident is causally connected to it. See, *Sorenson v. Industrial Comm'n., 281 Ill.App.3d 373, 666 N.E.2d 713, 217 Ill.Dec. 44 (1996)* In *Sorenson*, the Appellate Court affirmed the Commission's decision finding that a claimant's need for lumbar surgery was not related to the injury even though the claimant sustained a compensable back strain and was awarded temporary total disability, medical benefits and permanent partial disability benefits. After considering the entire record in the case at hand, we find that Petitioner failed to meet his burden of proving causal connection with respect to the need for a total knee replacement. Without a credible causal connection opinion from a medical expert, and furthermore considering Petitioner's unreliable testimony and the lack of persuasive evidence in the record; we find that the Arbitrator's Decision is not supported by a preponderance of the evidence.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 25, 2013 is hereby reversed and the Arbitrator's award is vacated. This case is remanded to the Arbitrator for a further hearing and determination of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399

14IWCC0293

N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 2 3 2014
RWW/plv
o-2/20/14
46

Ruth W. White

Charles J. DeVriendt

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

HOLLIS, NATHANIEL
Employee/Petitioner

Case# **12WC013618**

UNITED AIRLINES INC
Employer/Respondent

14IWCC0293

On 6/25/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0700 GREGORIO & ASSOCIATES
SEAN C STEC
TWO N LASALLE ST SUITE 1650
CHICAGO, IL 60602

0560 WIEDNER & MCAULIFFE LTD
ASALYAL L AKHMEROVA
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

14IWCC0293

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Nathaniel Hollis
Employee/Petitioner

v.

United Airlines, Inc.
Employer/Respondent

Case # **12** WC **13618**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Svetlana Kelmanson**, Arbitrator of the Commission, in the city of **Chicago**, on **May 16, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **3/12/2012**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$29,851.66**; the average weekly wage was **$621.91**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **1** dependent child.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

The parties stipulate Petitioner was temporarily totally disabled from **March 28, 2012**, through **December 18, 2012**.

Respondent shall be given a credit of **$15,838.02** for TTD, and **$4,501.32** for PPD advance, for a total credit of **$20,339.34**.

Respondent is entitled to a credit of **$70,179.20** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner further temporary total disability benefits of **$414.61**/week for **21 2/7** weeks, commencing **December 19, 2012**, through **May 16, 2013**, as provided in Section 8(b) of the Act.

Respondent shall pay related medical bills in Petitioner's Exhibit 6 pursuant to sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for the sums it or its group insurance carrier paid toward these bills, and Respondent shall hold Petitioner harmless from any claims by the group insurance carrier, as provided in Section 8(j) of the Act.

Respondent shall provide necessary and related prospective medical care recommended by Dr. Nam, pursuant to sections 8(a) and 8.2 of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

6/25/2013
Date

ICArbDec19(b)

JUN 25 2013

14IWCC0293

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner testified that he worked for Respondent for almost 14 years. At the time of the work accident, he had recently been promoted to a lead ramp serviceman, having worked as a ramp serviceman for 13 years prior to the promotion. His job duties included loading and unloading baggage, and fueling aircraft. Petitioner denied prior injuries, medical care or missing time from work because of problems with the left knee. Petitioner testified that on March 12, 2012, he injured his left knee while unloading luggage out of a plane. Petitioner explained that he was kneeling in the belly of the plane, turning and removing bags from a stack of luggage, when the bags collapsed on top of him. The falling bags struck him in the left knee and the groin. At first, Petitioner only noticed "a little pinching in the leg." When he finished unloading and stood up approximately 15 minutes later, he felt "a rush of pain" in the left leg and some pain in the groin. Petitioner notified his supervisor and finished the shift. Petitioner testified that at the end of the shift, the left knee felt sore and achy. The following day, the knee was very swollen and hurt a great deal. Petitioner went to work and completed an accident report. Respondent then sent him to Concentra Medical Centers (Concentra), the company clinic.

The medical records from Concentra show that on March 13, 2012, Petitioner described the accident consistently with his testimony. Dr. Israel diagnosed contusion of the left knee, sprain/strain of the medial collateral ligament, and inguinal strain. He prescribed physical therapy and released Petitioner to return to work on restricted duty. He also instructed Petitioner to see his primary care physician about a non-work related incidental finding. Petitioner followed up with Dr. Israel on March 16, March 23 and March 28, 2012, reporting no improvement with physical therapy. On March 28, 2012, Dr. Israel referred Petitioner to Dr. Mercier, an orthopedic surgeon.

Petitioner testified that on March 15, 2012, he saw his primary care physician, Dr. Zapata, who addressed his non-work related conditions. On March 28, 2012, Petitioner followed up with Dr. Zapata, mainly complaining of pain in the left knee and groin. Dr. Zapata ordered MRI studies of the left knee and left hip. An MRI of the left knee, performed March 29, 2012, showed: "osteochondral lesion versus a subchondral impaction fracture along the articular weightbearing surface of the medial femoral condyle," with findings suggestive of a developing unstable fragment; large bone contusions within the distal femur and proximal tibia; "[s]ignificant" tears of the medial meniscus and meniscal root with extrusion of the medial meniscus into the medial gutter; suspected tears of the meniscofemoral and meniscotibial ligaments; grade I to II medial collateral ligament sprain with prominent bursitis; and advanced underlying tricompartmental osteoarthritis with significant associated chondromalacia. An MRI of the left hip, performed April 3, 2012, was unremarkable. On April 5, 2012, Dr. Zapata referred Petitioner to Dr. Nam, an orthopedic surgeon.

The medical records from Dr. Nam show that on April 7, 2012, he examined Petitioner and reviewed the MRI studies. Dr. Nam opined that Petitioner's left knee and left hip conditions were causally connected to the work accident. He prescribed additional physical therapy and kept Petitioner off work. On May 11, 2012, Petitioner followed up with Dr. Nam, reporting improvement in the left hip, but not the left knee symptoms. Dr. Nam wanted to maximize conservative treatment, explaining that Petitioner might not get complete relief with arthroscopic

surgery because of his underlying osteoarthritis. Dr. Nam performed a cortisone injection into the knee and kept Petitioner off work. On May 25, 2012, Petitioner followed up with Dr. Nam, reporting only temporary relief after the cortisone injection. Dr. Nam discussed several treatment options, one of which was arthroscopic surgery with partial medial meniscectomy and microfracture of the medial femoral condyle. He cautioned that the surgery would not alleviate Petitioner's arthritic symptoms.

On June 23, 2012, Dr. Nam performed: a partial medial and lateral meniscectomy; chondroplasty of the medial femoral condyle, lateral tibial plateau and patellofemoral joint; and partial synovectomy. Intraoperatively, he noted chondral wear along the medial femoral condyle, but no fracture. Dr. Nam opted not to perform the microfracture procedure. Postoperatively, Petitioner underwent physical therapy, reporting significant persistent pain. On August 24, 2012, Dr. Nam performed another cortisone injection into the knee. On September 7, 2012, Dr. Nam performed X-rays, which showed a defined osteochondral lesion along the lower medial aspect of the medial femoral condyle, and patellofemoral arthritic changes. Dr. Nam ordered an MRI arthrogram and released Petitioner to return to work on sedentary duty. On October 1, 2012, Petitioner continued to complain of persistent pain. Dr. Nam reviewed the MRI arthrogram, noting that it showed diffuse cartilage loss along the medial femoral condyle and patellofemoral joint, with an area of probable osteonecrosis along the subchondral bone of the medial femoral condyle. Dr. Nam discussed several treatment options, including a knee replacement.

On December 17, 2012, Dr. D'Silva, an orthopedic surgeon, examined Petitioner at Respondent's request. Petitioner complained of persistent pain in the left knee, which significantly limited his activities of daily living. Dr. D'Silva reviewed the operative report and the MRI reports, and performed X-rays, which showed marked narrowing of the medial compartment and evidence of osteonecrosis with surrounding subchondral sclerosis of the medial femoral condyle. Dr. D'Silva attributed Petitioner's ongoing symptoms to osteonecrosis of the medial femoral condyle with tricompartmental arthritis. Regarding causal connection, Dr. D'Silva opined:

> "[The patient's] work-related injury is definitely unrelated to the osteonecrosis of his medial femoral condyle. The medical reason for this is that osteonecrosis of the knee is not caused by an acute injury. In regards to [the patient's] arthritis it is unrelated to the injury because it does not correspond to the mechanism of injury in that he was struck on the inner non weight-bearing aspect of his right [*sic*] knee not in the areas where his arthritis has been identified."

Dr. D'Silva declared Petitioner at maximum medical improvement, noting that Petitioner "would be limited to ground-level work or sitting job secondary to his avascular necrosis and underlying osteoarthritis."

On December 27, 2012, Petitioner followed up with Dr. Nam, complaining of persistent pain in the left knee. On January 28, 2013, Petitioner complained of severe pain and decided to proceed with a knee replacement.

On February 5, 2013, Dr. Nam performed a left total knee replacement surgery. Postoperatively, Petitioner began another course of physical therapy. On March 7, 2013, Petitioner reported to Dr. Nam that his pain was relatively well controlled. On April 4, 2013, Dr. Nam noted that Petitioner was making good progress, instructed him to continue physical therapy, and kept him off work.

On April 16, 2013, Dr. D'Silva issued an addendum report, agreeing that the knee replacement surgery was medically necessary. Dr. D'Silva's causal connection opinion remained unchanged.

Petitioner testified that he continues to treat with Dr. Nam. His left knee feels definitely improved, although he still has some pain. The groin pain has resolved. Petitioner further testified that after the accident, he worked on light duty until March 28, 2012. He has not returned to work since. Respondent paid temporary total disability benefits through December 18, 2012, and subsequently paid a permanent partial disability advance in the sum of $4,501.32.

Respondent introduced into evidence a certified Commission record of Petitioner's settlement in 2005 of a prior workers' compensation claim against Respondent for 27.5 percent loss of use of the right leg and 5 percent loss of use of the left leg. Respondent also introduced into evidence prior medical records relating to Petitioner's left knee. The medical records show that in November of 2004, Petitioner underwent surgery on the right knee. Postoperatively, Petitioner's treating physician, Dr. Treister, was concerned about the left knee "which has been symptomatic and is being made worse by being overstressed." However, during a follow-up visit in February of 2005, Petitioner voiced no complaints regarding either knee, and Dr. Treister released him to return to work full duty, instructing him to try to avoid kneeling. Petitioner testified that although Dr. Treister was concerned about the left knee, he did not prescribe any treatment or medication for the left knee condition. Petitioner denied any subsequent treatment for complaints related to the left knee until the work accident on March 12, 2012. Respondent then introduced into evidence an X-ray report dated February 27, 2012, showing that Petitioner underwent an X-ray of the left knee because of complaints of pain. The X-ray, which was ordered by Dr. Zapata, showed degenerative joint disease and osteoarthritis.

In support of the Arbitrator's decision regarding (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner contends that the work accident caused his previously mostly asymptomatic condition to become symptomatic, while Respondent contends that Petitioner failed to prove the work accident aggravated or exacerbated the underlying degenerative condition, necessitating the knee replacement surgery. Respondent further asserts that Petitioner is not credible because he denied prior problems with the left knee.

The Arbitrator notes that the medical records show Petitioner's left knee complaints in 2004 were fairly minor, compared to his complaints after the work accident on March 12, 2012. The 2005 settlement shows Petitioner settled the prior claim with respect to the left leg for 5 percent loss of use thereof. The medical records further show that Petitioner developed

degenerative joint disease and osteoarthritis of the left knee, which ultimately prompted him to consult Dr. Zapata, who ordered an X-ray. The X-ray was performed on February 27, 2012, two weeks before the work accident. However, Petitioner continued to work full duty, sustaining a work injury to the left knee on March 12, 2012, while unloading luggage out of a plane. The knee injury rendered Petitioner unable to perform his regular job duties because of persistent pain. Dr. Nam thought the pain was largely due to the underlying osteoarthritis, and had concerns that arthroscopic surgery might not sufficiently alleviate the pain. Dr. Nam decided to proceed with the arthroscopic surgery after the failure of conservative treatment. Postoperatively, Petitioner complained of significant persistent pain, and Dr. Nam performed a knee replacement surgery as a more lasting solution to Petitioner's pain complaints. Dr. D'Silva opined the need for the knee replacement surgery was due to the underlying osteoarthritis. Neither Dr. Nam nor Dr. D'Silva opined as to whether the work accident *accelerated* the need for the knee replacement surgery.

Based on the chain of events, the Arbitrator finds that the work accident accelerated the need for the knee replacement surgery because it caused a previously mildly to moderately symptomatic condition to become severely symptomatic, to the point where Petitioner could no longer perform his job duties, even after recovering from the arthroscopic surgery. See International Harvester v. Industrial Comm'n, 93 Ill. 2d 59, 63-64 (1982) ("A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury"); Twice Over Clean, Inc. v. Industrial Comm'n, 214 Ill. 2d 403 (2005) (The record must support a legitimate inference that the work activity was a causative factor in hastening the onset of the disabling condition); Engleking v. Ashland Chemical, 12 IWCC 1082 ("Based on petitioner's testimony, and the review of the available exhibits and with the standard enumerated by the Illinois Supreme Court, petitioner has clearly established by a preponderance of the evidence that the accident of May 18, 2007, and the related arthroscopic procedures are at least 'a contributing cause' in the worsening or acceleration of his preexisting osteoarthritic condition resulting in the need for bilateral knee replacement surgery").

The Arbitrator further finds that Petitioner has not yet reached maximum medical improvement.

In support of the Arbitrator's decision regarding (J), were the medical services that were provided to Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator awards related medical bills in Petitioner's Exhibit 6 pursuant to sections 8(a) and 8.2 of the Act, giving Respondent credit for the sums it or its group insurance carrier paid toward these bills. Respondent shall hold Petitioner harmless from any claims by the group insurance carrier, as provided in Section 8(j) of the Act.

The Arbitrator notes that Petitioner reserved the issue of medical bills not introduced into evidence at the arbitration hearing.

In support of the Arbitrator's decision regarding (K), is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

The Arbitrator awards necessary and related prospective medical care recommended by Dr. Nam, pursuant to sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision regarding (L), what temporary benefits are in dispute, the Arbitrator finds as follows:

The parties stipulate Petitioner was temporarily totally disabled from March 28, 2012, through December 18, 2012. The Arbitrator awards further temporary total disability benefits from December 19, 2012, through the date of the arbitration hearing on May 16, 2013.

In support of the Arbitrator's decision regarding (M), should penalties or fees be imposed upon Respondent, the Arbitrator finds as follows:

As noted, neither Dr. Nam nor Dr. D'Silva opined as to whether the work accident accelerated the need for the knee replacement surgery. Thus, a genuine dispute remained as to whether the knee replacement surgery is causally connected to the work accident. The Arbitrator further notes that the group insurance carrier paid for the knee replacement surgery, and Respondent advanced Petitioner permanency benefits in the sum of $4,501.32. The Arbitrator finds that penalties and attorney fees are not warranted under these circumstances.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Janice Davis,

Petitioner,

vs.

No. 11WC029372

14IWCC0294

Comfort Keepers,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, the necessity of medical treatment and prospective medical care, and being advised of the facts and law, modifies the decision of the Arbitrator as stated below, and otherwise affirms and adopts the decision of the Arbitrator which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

The Arbitrator found that Petitioner's condition of ill-being was causally related to the April 3, 2011, undisputed accident through November 21, 2011, the date of Dr. John Krause's initial section 12 examination report. The Commission disagrees.

On November 21, 2011, Dr. Krause performed a section 12 examination at Respondent's request. Dr. Krause assessed that Petitioner had a history of a right ankle contusion and symptom magnification, noting that there was no evidence of syndesmosis injury and he could not rule out a medial talar osteochondral lesion although Petitioner was asymptomatic. Dr. Krause also noted that he did not have Petitioner's May 4, 2011, right ankle MRI for review and he could not recommend future treatment with certainty until he reviewed the MRI. Dr. Krause recommended that Petitioner undergo a Functional Capacity Evaluation and a repeat MRI. On January 23, 2012, Dr. Krause reviewed Petitioner's May 4, 2011, MRI and generated an addendum to his initial section 12 report. Dr. Krause assessed that Petitioner had a history of a right ankle contusion, an asymptomatic medial talar osteochondral lesion and symptom magnification. Dr. Krause noted that Petitioner showed no evidence of syndesmosis injury, opined that Petitioner should not have surgery and reiterated his recommendation that Petitioner undergo a repeat MRI. On March 30, 2012, Petitioner underwent a repeat right ankle MRI. On August 13, 2012, Dr. Krause reviewed the 2012 MRI and opined that Petitioner required no additional medical treatment and should undergo a Functional Capacity Evaluation.

The Commission finds that Petitioner's right ankle condition was causally related to the undisputed accident through March 30, 2012, the date of Petitioner's repeat right ankle MRI. The Commission notes that Dr. Krause recommended Petitioner undergo a repeat MRI in his November 21, 2011, section 12 report and in his January 23, 2012, section 12 report addendum. After reviewing the repeat MRI, Dr. Krause opined that Petitioner required no additional medical treatment for her right ankle. The Commission finds that Petitioner underwent the March 30, 2012 MRI, only because Dr. Krause recommended it and Dr. Krause did not form a final opinion until he reviewed the 2012 MRI. The Commission awards Petitioner all medical treatment related to her right ankle and incurred on or before March 30, 2012. The Commission affirms the Arbitrator's credibility findings and denial of prospective medical care.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed on February 19, 2013, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner all reasonable and necessary medical expenses related to her right ankle condition, incurred on or before March 30, 2012, under §8(a) and §8.2 of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

No bond is required for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
SM/db APR 2 3 2014
o-02/27/14
44

Stephen J. Mathis

David L. Moore

Mario Basurto

DAVIS, JANICE
Employee/Petitioner

Case# **11WC029372**

14IWCC0294

COMFORT KEEPERS
Employer/Respondent

On 2/19/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

1256 HOLTKAMP LIESE ET AL
JOHN KAFOURY
217 N 10TH ST SUITE 400
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JANICE DAVIS,
Employee/Petitioner

v.

COMFORT KEEPERS,
Employer/Respondent

Case # 11 WC 29372

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen H. Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **1/24/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **4/3/11**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$17,718.78**; the average weekly wage was **$340.75**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **1** dependent child.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$880.00** for other benefits, for a total credit of **$880.00**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay all reasonable and necessary medical services for petitioner's right ankle from 4/3/11 through 11/21/11, as provided in Section 8(a) and Section 8.2 of the Act. All treatment after 11/21/11 was not reasonable or necessary to cure or relieve the petitioner from the effects of the injury on 4/3/11.

Petitioner's claim for prospective medical treatment is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

2/8/13
Date

ICArbDec19(b)

FEB 19 2013

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 39-year-old caregiver alleges she sustained an accidental injury that arose out of and in the course of her employment with respondent on 4/3/11. Petitioner's duties included taking care of elderly and handicapped people. She would help them get ready for bed, feed them, clothe them, bathe them, etc. Petitioner denied any problems with her right ankle before the injury on 4/3/11.

On 4/3/11 while working for respondent petitioner fell as she tried to jump over a bed to stop her client from falling. Petitioner testified that her client was standing with a walker on the opposite side of the bed and began to fall over the walker. Petitioner tried to jump over the bed in order to assist the client. As she attempted to jump over the bed she hit the bed rail with her right ankle and twisted it. Petitioner experienced immediate pain in her right ankle.

Petitioner sought treatment that day at the Methodist Medical Center of Illinois emergency room. The attending doctor was Dr. Diana Doll. Petitioner denied any history of falling. Petitioner reported that she injured herself about five hours ago. She gave a history of injuring herself lifting a patient onto bed at work. Petitioner complained of pain over the right ankle. She also described difficulty bearing weight due to the pain. Local soft tissue swelling was noted over the right ankle. The skin over the right lateral malleolus was intact without any lacerations or abrasions. X-rays of the right foot and ankle were taken. No radiographic evidence of an acute fracture was noted. Petitioner's primary diagnosis was a sprain/strain of the right lateral malleolus and difficulty walking. Petitioner was placed in an air cast. Petitioner was instructed to follow-up with an appointment at IWIRC.

After visiting the emergency room petitioner returned to work. She testified that she was doing pretty good but still had pain. Nonetheless she continued to work. As petitioner continued to work she noticed that it got harder and harder for her to perform the duties of her job and for respondent to find alternate work for her. As a result she quit her job with respondent and applied for Social Security disability. Petitioner was denied Social Security disability.

On 5/3/11 petitioner presented to IWRC for an initial evaluation of a right ankle contusion. Petitioner stated that the injury occurred on 4/3/11 at 7:35 PM. Petitioner reported that she hit the lateral border of her right ankle on the bed rail after jumping over the bed to keep a resident from falling. She rated her pain at a 6/10 on a scale of 10. She complained of intermittent numbness and tingling in the foot and ankle and all five toes, swelling, tenderness, and sharp pains. She stated that it felt like her foot was starting to turn inward. She stated that she had been taking over-the-counter ibuprofen and icing her ankle for symptom relief. Petitioner reported that she did not recall twisting her right ankle. An examination

revealed palpable tenderness along the distal fibula and over the lateral malleolus, mildly limited dorsiflexion, audible pop over the lateral ankle at end dorsiflexion, lateral ankle pain with ankle dorsiflexion and inversion, and an altered gait favoring the right lower extremity. Petitioner was assessed with a right ankle contusion with no improvement since the injury. An MRI of the right ankle was ordered. Petitioner was instructed to continue wearing the air cast and not take more than two pills of ibuprofen every eight hours for pain. She was released to resume her full duty job without restrictions.

On 5/4/11 petitioner underwent an MRI of the right ankle. The impression was osteochondral injury of the medial talar dome without unstable fragment; low-grade deltoid ligament sprain; minimal posterior tibialis and flexor digitorum longus tenosynovitis; small posterior subtalar joint effusion; and low-grade chronic dorsal talonavicular ligament strain.

On 5/6/11 petitioner returned to IWIRC for evaluation of her right ankle and to review the results of the MRI. Petitioner noted no improvement. She reported that she was taking ibuprofen every 6 to 8 hours. Petitioner complained of continual lateral ankle pain, most notable with weight-bearing. She denied any prior injury to her ankle, but noted a fractured toe several years ago. Her examination remained unchanged. The results of the MRI revealed osteochondral injury at the medial talar dome, without unstable fragment; and mild sprain to the deltoid ligament. Petitioner was assessed with a right ankle contusion – osteochondral injury medial talar dome, and sprain to the deltoid ligament of the right ankle. Petitioner was referred for orthopedic consultation regarding the osteochondral injury. Use of her air cast was discontinued. She was provided with a lace up ankle brace that she was to wear when up and about. She was continued on ibuprofen. She was also directed to continue her regular work duties. Petitioner was directed to return to IWIRC after her orthopedic consultation.

On 5/17/11 petitioner presented to Dr. D'Souza. Petitioner gave a history of injuring her right ankle on 4/3/11 while she is working. Petitioner reported that the client she was working with started to fall after pulling back the curtain. She stated that she jumped over the bed to grab the client and hit her right ankle and twisted it at the same time. She gave a history of her treatment to date. Petitioner reported no improvement in her pain level since the date of injury. She reported her pain as a 5/10. She noted that it was well localized inconsistently along the anterolateral aspect of her ankle. She also reported some pain radiating more proximally up the ankle. She denied any numbness or tingling. She reported previous injuries in the past to her right ankle, and also reported toe fractures some years ago. Petitioner reported that pressure on the right ankle makes it worse and creates a radiating pain anterolaterally. Petitioner reported some improvement when her foot is elevated or she has not been walking it. An examination

revealed exquisite tenderness over the anterolateral joint line, as well as over the distal tib-fib joint. This pain was also reproduced by abduction and external rotation. No tenderness was noted medially. No effusion or crepitus with range of motion was noted. Drawer testing was a Grade 1. Her motor exam was intact. An x-ray revealed extreme increase in the distal tib-fib space. Dr. D'Souza was concerned that petitioner might have a chronic syndesmotic injury. Dr. D' Souza noted that this did not really show up very well on the MRI but felt that based on her level of symptomatology and history on physical exam, an examination under anesthesia would be warranted. If instability was noted at the distal tib-fib joint, he recommended an ORIF with plates and screws. He further indicated that he would undertake an ankle arthroscopy at the same time to evaluate the chondral surfaces and address the medial OCD. Petitioner was released to full duty work. On 5/26 /11 petitioner notified Dr. D'Souza that the recommended surgery had not been authorized by respondent.

On 5/20/11 petitioner returned to IWIRC for an evaluation. She reported that her condition was unchanged. She indicated that she had been seen by Dr. D'Souza and was anticipating surgery on 5/27/11. She was also wearing a cam walking boot prescribed by Dr. D'Souza. Petitioner was examined and her assessment remained the same. Petitioner was instructed to continue wearing the cam boot and follow-up with Dr. D'Souza as scheduled. She was continued on full duty work.

On 6/3/11 and 7/1/11 petitioner returned to IWIRC. Petitioner stated that she was waiting for workers' compensation to approve her surgery. She was still wearing a walking air cast. She noted that her condition remained unchanged. Petitioner was examined and the plan of care remained unchanged.

On 6/14/11 petitioner returned to Dr. D'Souza. Petitioner reported that she was still having significant pain in her ankle. She stated that she was wearing a cast boot, but was having a lot of difficulty weight-bearing even with the boot. An examination revealed no effusion and a profound tenderness over the lateral talus, the lateral joint line, as well as over the distal tib-fib joint and pain with external rotation adduction. Dr. D'Souza informed petitioner that they were in a bit of a holding pattern based on the lack of surgical authorization. Dr. D'Souza was of the opinion that petitioner's current condition of pathology was attributable to her injury in April 2011. He instructed her to follow-up once the surgery had been approved. He again recommended an ankle arthroscopy along with an open reduction internal fixation of the syndesmosis if the x-ray showed demonstrable instability at the tib-fib joint.

On 8/24/11 and 8/31/11 petitioner was re-examined and was returned to work with restrictions. These restrictions included no prolonged walking over three minutes without a three minute rest.

On 11/21/11 the petitioner underwent a section 12 examination performed by Dr. John Krause at the request of the respondent. Petitioner's chief complaint was right ankle pain. She gave a history of working as a caretaker for Comfort Keepers. She stated that she was working at a retirement center on 4/3/11 when she was helping a patient get up from bed. As she saw the patient begin to fall she jumped across the bed to catch her. In the process, she hit her right ankle against the rail and twisted her ankle. She stated that she was unable to keep up that day and was seen at Methodist Medical Center emergency room. Thereafter she followed up with IWIRC and Dr. D'Souza. Petitioner noted difficulty weight-bearing in her short boot. She believed her symptoms were worsening. Dr. Krause performed a record review and physical examination. His assessment was history of right ankle contusion; cannot rule out medial talar osteochondral lesion albeit symptomatic; no evidence of syndesmosis injury either clinically or radiographically; and symptom magnification. Dr. Krause noted that petitioner had multiple red flags regarding any type of aggressive treatment. Dr. Krause did not believe that any type of surgical treatment was warranted at that time. Dr. Krause did not have the MRI images available for review. Given the fact that it was over six months old he was of the opinion that she would need a new MRI. Dr. Krause found no evidence of syndesmosis instability on examination. He was uncertain how this diagnosis was made. He was of the opinion that he would definitely not recommend a syndesmosis reconstruction. He could not explain why the petitioner could not bear weight or was unwilling to bear weight. Dr. Krause was of the opinion that after reviewing the MRI, if it is unremarkable, he would recommend a functional capacity evaluation. Based on his examination findings and the x-ray he took he saw no reason that petitioner could not be working at least on light duty.

On 1/23/12 Dr. Krause drafted an addendum report following receipt of the MRI images dated 5/4/11. He reviewed all the images and was of the opinion that petitioner had changes in the medial talar dome consistent with an osteochondral lesion, and the syndesmosis was normal. His assessment was history of right ankle contusion; asymptomatic medial talar osteochondral lesion of unknown age; no evidence of syndesmosis injury; and, symptom magnification. Dr. Krause was of the opinion that osteochondral lesions can cause significant symptoms in some patients. However, when he examined the petitioner she did not appear to have symptoms related to her medial talar dome. Dr. Krause reiterated that petitioner had multiple red flags when he examined her including an inability to bear weight. He was of the opinion that the osteochondral lesion that was seen on the MRI would not lead a patient to be unable to bear weight, but may cause some pain with weight-bearing and with activities. Dr. Krause again recommended a repeat MRI and a functional capacity evaluation. Dr. Krause saw no evidence of syndesmosis injury on the MRI or when he examined the petitioner. As such, he did not recommend a

major syndesmosis reconstruction. He was also of the opinion that he would not rush into a surgical procedure based on the petitioner's symptom magnification. Dr. Krause reiterated his belief that petitioner could be working at least a light duty. He noted that she may have difficulty with standing for eight hours per day and should be able to do standing work with intermittent standing.

On 1/24/12 petitioner followed up with Dr. D'Souza. She reported that she had undergone an IME and that the doctor was of the opinion that no surgery was indicated. She reported that she continues to have pretty severe pain. Petitioner was still wearing her cam boot. An examination revealed continued pain over the lateral joint line. A grade 2 drawer was noted with both plantar flexion and dorsiflexion. Her external rotation adduction test was negative with no tenderness proximally along the tib-fib joint. Some tenderness and swelling over the peroneals with reproducible pain by inversion was noted. A new MRI was recommended to evaluate the lateral chondral surfaces, the lateral ligament complex, and the peroneal tendons. Dr. D'Souza was of the opinion that it was reasonable for petitioner to maintain sedentary work restrictions.

On 3/30/12 petitioner underwent a repeat right ankle MRI. The conclusions were small, low-grade capital OCD involving the medial aspect of the talar dome with prominent surrounding marrow edema.

On 4/26/12 petitioner returned to Dr. D'Souza. It was noted that the repeat MRI of the right ankle confirmed an osteochondral defect medially and attenuation of lateral ligaments. The peroneal tendons appeared normal. An examination demonstrated a positive drawer which reproduced pain primarily along the lateral side. She also had a trace amount of tenderness medially. Dr. D'Souza noted that petitioner continued to smoke on a daily basis. He discussed with her how this affects her pathology and prognosis. He recommended an injection with cortisone and lidocaine, and instructed her to stop smoking. He continued her on sedentary duty, and dispensed and ASO brace to help with some of her instability and allow her to come out of her cast boot which she had been utilizing pretty often. On 6/26/12 petitioner followed up with Dr. D'Souza. She reported that her condition was unchanged and that the injection helped for about two months. Dr. D'Souza recommended an arthroscopic debridement with potential retrograde drilling and cartilage transplantation if necessary, and a lateral ligament reconstruction. Petitioner reported that she had stopped smoking.

On 9/7/12 the evidence deposition of Dr. Krause was taken on behalf of the respondent. Dr. Krause is an orthopedic surgeon that specializes in lower extremities, knees, legs, feet, and ankles. Dr. Krause was of the opinion that the ankle contusion he diagnosed was causally related to the injury petitioner sustained, but had resolved by the time he had examined her. With respect to the bone bruise,

or the medial talar osteochondral lesion, he was of the opinion that this too was related to the injury, but since it was asymptomatic he did not recommend any further treatment for it. Dr. Krause was of the opinion that the symptoms petitioner was having when he examined her were not causally related to the injury she suffered on 4/3/11, or the abnormality he saw on the MRI.

On cross examination Dr. Krause indicated that the only reason he believed petitioner was not capable of working full duty the first time he saw her was that he did not have all the information with regard to her diagnostic tests. He indicated that had he had that information the first time he examined her he would have found her capable of working full duty. Dr. Krause was of the opinion that petitioner's osteochondral lesion was asymptomatic because she did not have pain when he pushed on that area, which was the inside part of the ankle at the ankle joint. He noted that the syndesmosis is on the outside part of the ankle, just above the ankle joint. Dr. Krause was of the opinion that Dr. D'Souza's findings were also consistent with an osteochondral lesion. Dr. Krause was of the opinion that petitioner's symptom magnification is what was causing her symptoms. He was of the opinion that her magnified symptoms were not localized to one specific area, she had normal MRIs on the lateral side of the ankle, and she had a negative stress view. For these reasons Dr. Krause with of the opinion that petitioner did not need any surgery. Dr. Krause noted that upon review of the MRIs he did not notice any significant pathology in the ligaments that warranted treatment. Dr. Krause was of the opinion that since petitioner had no symptoms related to the medial talar osteochondral lesion that surgery was not indicated.

On 8/13/12 Dr. Krause drafted a second addendum report. This report was based on a receipt of a new MRI dated 3/30/12. He was of the opinion that the images showed what appeared to be persistent edema in her medial talus. He saw no other distinct bony injury, but noted that it was a low quality MRI. His assessment was history of right ankle contusion; history of symptom magnification; right medial talar osteochondral lesion versus bone bruise, asymptomatic; no radiographic or objective evidence of syndesmosis pathology; and symptom magnification. He stated that the new MRI did not change his opinion that the petitioner should not have surgical reconstruction. He noted that she did not have pain localized to her medial talar osteochondral lesion, and had no objective findings of syndesmosis instability. He was of the opinion that if there is a suggestion that petitioner needs a syndesmosis reconstruction he would try to demonstrate that objectively with either a CT scan or MRI showing both ankles and showing the abnormality. He was of the opinion that to do a syndesmosis reconstruction for a subjective finding has a very guarded prognosis especially in someone with symptom magnification. Dr.

Krause was of the opinion that petitioner needed no further treatment other than a functional capacity evaluation, and that she could return to full duty work without restrictions.

On 12/6/12 the evidence deposition of Dr. D'Souza, an orthopedic surgeon that specializes in foot and ankle reconstruction, was taken on behalf of the respondent. Dr. D'Souza wanted to perform an examination under anesthesia to ascertain whether the tibia and fibula were moving apart from each other. If they where this would imply the ligaments to connect these two bones have been either stretched beyond normal or totally torn. If the ligaments were damaged Dr. D'Souza wanted to perform a surgery to stabilize the bones and get the ligaments to heal properly. When asked why he could not perform this examination during his physical examination he indicated that it would hurt too much to do it. Dr. D'Souza testified that the only change from the first time he saw her and the last time he saw her on 1/24/12 was that the instability had increased a little bit. Dr. D'Souza was of the opinion that the instability noted on 1/24/12 was with respect to a different set of ligaments. It was not directly related to the syndesmotic ligaments. He further noted that the other improvement he saw on 1/24/12 was that petitioner was not having pain on the provocative tests anymore, and the tenderness that she had six month earlier was also improving. Dr. D'Souza ordered an MRI that showed an osteochondral defect. He could not give an opinion on whether or not this defect was causally related to the accident. He was of the opinion that based on the fact that there was bone bruising or edema in the region where there was a chondral defect implies that there is a new injury. Dr. D'Souza noted that there is debate in the literature as to whether you can ever tell if one of those chondral injuries is something acute or something chronic. He was of the opinion that typically it is related to a causal event like somebody getting hurt and still having some bruising a few weeks later.

On 4/26/12 Dr. D'Souza noted that petitioner had had a stroke and therefore he wasn't rushing in to do surgery on her. He also noted that she was still smoking, and discussed with her how smoking affects treatment recommendations. At that time Dr. D'Souza was not recommending surgery. On 6/26/12 petitioner told Dr. D'Souza that she had stopped smoking and felt better after the injection, but was still complaining of instability in the ankle. Based on these complaints and the fact that she had failed to improve with the brace and injections, Dr. D'Souza was recommending surgery that would address the cartilage defect, any instability in the ankle joint, and any instability in the lateral ligaments at the ankle joint itself.

Dr. D'Souza opined that the osteochondral defect was causally related to the accident given that it was a new injury and there was bruising there. He further opined that the syndesmotic instability in the

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tibia fibular area and the lateral ligament instability are causally related to the accident that occurred on 4/3/11. Dr. D'Souza opined that surgery for all these three conditions would be causally related to the accident. Dr. D'Souza was of the opinion that if the petitioner did not undergo the recommended surgeries she would be at maximum medical improvement. On the other hand if she underwent the recommended surgery petitioner would have a 75% chance of getting better. Dr. D'Souza was of the opinion that petitioner's physical complaints were consistent with his diagnosis.

On cross examination Dr. D'Souza noted that he did not know which side of petitioner's ankle she hit at the time of the injury. He was of the opinion that osteochondral defects can occur from a myriad of mechanisms, and a direct blow is one of them. He further stated that the most common cause for defect to occur is a twisting injury that causes the bones to impact each other in a way that they normally should not. Dr. D'Souza opined that if petitioner did not have the instability and pain on the lateral side of her foot, and the osteochondral lesion was her only problem, he would not initially recommend surgical intervention to fix the problem. Dr. D'Souza admitted that petitioner was asymptomatic on the medial aspect of her ankle originally, and it wasn't until eight months later that he noted that petitioner had some mild tenderness in that area. He was of the opinion that these findings correlate to the natural history of osteochondral defects. Dr. D'Souza was of the opinion that petitioner was not very symptomatic on the inside of her ankle when he first saw her. He noted that the majority of her symptoms were on the lateral side of the ankle joint. He stated that it was not unusual that a sprain to the deltoid ligament be asymptomatic at first and then start to hurt a year later. Dr. D'Souza was of the opinion that all the findings as seen on the MRI were not related to the anterior ligaments or the syndesmosis. He was further of the opinion that these types of injuries may not be seen on an MRI done within a couple weeks of the injury. However if a repeat MRI is done six months or year later you will see the ligaments just sort of start to melt away. Dr. D'Souza could not opine that petitioner has a syndesmotic injury without performing an examination under anesthesia. He was of the opinion that the MRI and x-rays were inconclusive as to whether or not petitioner had a syndesmotic injury. However, based his physical findings and her subjective complaints, Dr. D'Souza was of the opinion that petitioner may have a syndesmotic injury. He was further of the opinion that although patients tend to over magnify their symptoms they cannot fake instability.

Respondent offered into evidence medical records from Methodist Medical Center of Illinois dated 6/26/10 where petitioner presented with toe pain. Petitioner stated that she dropped a board on her right foot last night and her three middle toes were bothering her. She complained of pain affecting the right

foot. She described it as throbbing in nature and localized. No radiation of pain was noted. She was examined and diagnosed with a contusion of the dorsum of the toes of the right foot. No other prior medical records related to the right ankle were offered into evidence.

Petitioner testified that her ankle is currently very unstable. She testified to problems with bearing weight on her right foot. Despite the different braces prescribed by Dr. D'Souza petitioner testified that she still limps and has pain. She further testified that she has trouble stepping down and bearing weight on her right foot. She stated that when she does this she has severe pain. Petitioner testified that she would like to undergo the surgery recommended by Dr. D'Souza, but public aid has indicated that they would not pay for the surgery because it was too expensive.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

It is unrebutted that petitioner sustained an accidental injury that arose out of and in the course of her employment on 4/3/11. However, the issue as to whether or not her current condition of ill-being is causally related to that injury, and what her actually condition is, are in dispute.

Between 1/6/08 and 4/3/11 petitioner visited the emergency room of Methodist Medical Center 34 times. Some of these visits did involve an injury to petitioner's right foot. However, none of them resulted in any extensive treatment or any restrictions.

The mechanism of injury on 4/3/11 is a bit unclear. In some records petitioner noted that she twisted her ankle, and in others she denied any twisting injury. What is not in dispute is that petitioner had soft tissue swelling over the right ankle, without any lacerations or abrasions. X-rays showed no fracture. She was diagnosed with a sprain/strain of the right lateral malleolus and difficulty walking.

At her initial visit at IWIRC petitioner reported that she did not recall twisting her right ankle. She was assessed with a right ankle contusion and no improvement since the injury. The first MRI showed osteochondral injury of the medial talar dome without unstable fragment; low-grade deltoid ligament sprain; minimal posterior tibialis and flexor digitorum longus tenosynovitis; small posterior subtalar joint effusion; and low grade chronic dorsal talonavicular ligament strain.

When petitioner presented to Dr. D'Souza she reported that she twisted her ankle when she injured it. This was inconsistent with what she reported at IWIRC. She complained that the pain was localized inconsistently along the anterolateral aspect of the ankle. She denied numbness and tingling. She still had pain when she put pressure on the right ankle. Although Dr. D'Souza was concerned that petitioner might have a chronic syndesmotic injury, he noted that it did not show up on the MRI. Based on her level

of symptomatology, history and physical exam, Dr. D'Souza wanted an examination under anesthesia, and then surgical intervention if warranted. If he found instability at the distal tib-fib joint, he wanted to do an ORIF with plates and screws. He also wanted to undertake an ankle arthroscopy at the same time to evaluate the chondral surfaces and address the medial OCD.

On 11/21/11 when petitioner presented to Dr. Krause she gave a history of hitting her ankle against the rail and twisting her ankle. Dr. Krause could not rule out a medial talar ostechondral lesion that was asymptomatic, but did not see any evidence of a syndesmosis injury or instability either clinically or radiographically. For this reason he definitely was against any syndemosis reconstruction. He could not explain why the petitioner could not bear weight or was unwilling to bear weight, but did note symptom magnification. When Dr. Krause had the opportunity to review the actual MRI images he was of the opinion that petitioner had changes in the medial talar dome consistent with an osteochondral lesion, but the syndesmosis was normal. Given the fact that the medial talar osteochondral lesion was asymptomatic, and the syndesmosis was normal, and petitioner demonstrated symptom magnification, Dr. Krause was of the opinion that no surgical intervention was necessary.

Petitioner returned to Dr. D'Souza on 1/24/12 and was still complaining of pain over the lateral joint line. An examination revealed that her external rotation adduction test was negative with no tenderness proximally along the tib-fib joint. A new MRI of the right ankle was recommended. The conclusions were small, low grade capital OCD involving the medial aspect of the talar dome with prominent surrounding marrow edema. Dr. D'Souza believed that these findings confirmed an osteochondral defect medially and attenuation of lateral ligaments. On 6/26/12 Dr. D'Souza was recommending an arthroscopic debridement with potential retrograde drilling and cartilage transplantation if necessary, and a lateral ligament reconstruction. On 12/6/12 Dr. D'Souza opined that the instability on 1/24/12 was to a different set of ligaments.

At his deposition Dr. Krause was of the opinion that petitioner's ankle contusion had resolved and was causally related to the injury. He was further of the opinion that petitioner's bone bruise, or medial talar osteochondral lesion, was related to the injury, but since it was asymptomatic he did not recommend any further treatment for it. Dr. Krause did not believe that petitioner's current symptoms were causally related to the accident on 4/3/11, or the abnormality seen on the MRI. Dr. Krause noted that when he pushed on the area where the osteochondral lesion was located the petitioner did not have any pain. Dr. Krause was of the opinion that petitioner symptom magnification is what was causing her symptoms, and they were not related to one specific area. Dr. Krause noted that after reviewing the MRIs he did not

notice any significant pathology in the ligaments that warranted treatment. Dr. Krause was of the opinion that if there was any suggestion that petitioner needed a syndesmosis reconstruction he would try to demonstrate that objectively with either a CT scan or MRI showing both ankles and showing the abnormality.

Alternatively, Dr. D'Souza wanted to perform an examination under anesthesia to ascertain whether the tibia and fibula were moving apart from each other. He stated that if they were this would imply that the ligaments to connect these two bones had been either stretched beyond normal, or totally torn. If he found the ligaments were damaged he wanted to perform surgery to stabilize the bones and get the ligaments to heal properly. When asked why he could not perform this during his physical examination, Dr. D'Souza indicated that it would hurt too much to do it. Dr. D'Souza was of the opinion that the instability he noted on 1/24/12 was with respect to a different set of ligaments, and not related to the syndesmotic ligaments. Dr. D'Souza noted that other improvement he saw on 1/24/12 was that the petitioner was not having pain on the provocative tests anymore, and the tenderness that she had had six month earlier was also improving. Dr. D'Souza could not give an opinion on whether or not the osteochondral defect was causally related to the accident.

On 6/26/12 Dr. D'Souza was recommending surgery that would address the cartilage defect, any instability in the ankle joint, and any instability in the lateral ligaments at the ankle joint itself. On this date Dr. D'Souza opined that the osteochondral defect was causally related to the accident given that it was a new injury and there was a bruising there. He further opined that the syndesmotic instability in the tibia fibular area and the lateral ligament instability are causally related to the accident that occurred on 4/3/11, and surgery for these conditions would be causally related to the accident.

During his deposition Dr. D'Souza admitted that he did not know which side of the petitioner's ankle she hit at the time of the injury. He also admitted that osteochondral defects can occur from the myriad of mechanisms, and a direct blow is one of them. He further stated that the most common cause is a twisting injury. He was of the opinion that if petitioner did not have instability and the pain on the lateral side of her foot, and the osteochondral lesion was her only problem, he would not recommend surgical intervention to fix a problem. Dr. D'Souza admitted that the petitioner was originally asymptomatic on the medial aspect of her right ankle, and it wasn't until eight months later that she reported any mild tenderness in that area. Dr. D'Souza believed that these findings correlate to the natural history of osteochondral defects. He was of the opinion that all of the findings on the MRI were not related to the anterior ligaments or the syndesmosis. He stated that these types of injuries may not be seen

on an MRI done within a couple weeks of the injury, however if a repeat MRIs done six months or year later you see the ligaments disorder start to melt away. He also admitted that he could not opine that petitioner had a syndesmotic injury without performing an examination under anesthesia since the MRIs and x-rays were inconclusive.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that her current condition as it relates to her right foot is causally related to the injury she sustained on 4/3/11. The arbitrator finds it significant that the mechanism of petitioner's injury is inconsistent in the records as to whether or not she actually twisted her ankle when she had the injury. The arbitrator also notes inconsistencies between the diagnostic findings and petitioner subjective complaints. Additionally the arbitrator finds the opinions of Dr. D'Souza appear to be based primarily on assumptions that are not supported by the credible medical evidence. Dr. D'Souza admitted that there was no objective evidence to support a syndesmotic injury, and had inconsistent opinions on the cause of the osteochondral defect. On 1/24/12 Dr. D'Souza could not give an opinion on whether or not the osteochondral defect was causally related to the accident, and then on 6/26/12 was of the opinion that the osteochondral defect was causally related to the accident given that if was a new injury and there was bruising there. However, the arbitrator notes that Dr. D'Souza admitted that he did not know which side of the petitioner's ankle she hit at the time of the injury. Although he was of the opinion that the most common cause is a twisting injury, the evidence is inconsistent as to whether or not petitioner twisted her ankle at the time of the injury.

Alternatively, Dr. Krause was of the opinion that petitioner sustained an ankle contusion that was causally related to the injury, but had resolved. He was also of the opinion that petitioner's medial talar osteochondral lesion was also related to the injury, but noted that it was asymptomatic and did not require any further treatment. He noted that despite petitioner's subjective complaints, when he pushed on the area where the osteochondral lesion was located the petitioner had no pain.

Lastly, the arbitrator finds Dr. Krause's opinion that petitioner had a problem with symptom magnification is supported by her prior medical records. After initially denying it, petitioner admitted that it was possible that she had presented to the emergency room 34 times in a three year period preceding the injury.

The arbitrator finds the opinions of Dr. Krause more credible in that they are more consistent with the credible medical evidence than those of Dr. D'Souza. The arbitrator finds the opinions and

recommendations of Dr. D'Souza are based on petitioner's subjective complaints, which are inconsistent with the objective findings, and possibly related to her symptom magnification.

The arbitrator adopts the opinions of Dr. Krause and finds that as a result of the injury on 4/3/11 petitioner sustained a sprain/strain of the right lateral malleolus that had resolved, and a medial talar osteochondral lesion, that was asymptomatic.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having adopted the opinions of Dr. Krause with respect to the issue of causal connection, the arbitrator finds all medical treatment after 11/21/11, the date Dr. Krause examined petitioner and offered his opinions, was not reasonable and necessary to cure or relieve petitioner from the effects of the injury on 4/3/11. The arbitrator finds the subjective symptoms petitioner has, and continues to experience are inconsistent with the diagnostic tests that have been performed. The arbitrator finds the petitioner has a history of symptom magnification based on her 34 visits to the emergency room in the three year period preceding the accident.

Based on the above as well as the credible evidence the arbitrator finds the respondent shall pay all reasonable and necessary medical expenses petitioner incurred for her right ankle from 4/3/11 through 11/21/11 pursuant to section 8(a) and 8.2 of the Act. The arbitrator denies all medical treatment after 11/21/11 finding it was not reasonable or necessary to cure or relieve the petitioner from the effects of the injury on 4/3/11.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Throughout the medical evidence Dr. D'Souza has outlined various surgeries that he might perform on petitioner while performing an examination under anesthesia. The arbitrator finds these surgeries are not based on any credible objective evidence and therefore are not reasonable or necessary to cure or relieve petitioner from the effects of the injury she sustained on 4/3/11. The arbitrator finds Dr. D'Souza's decision to perform surgery is based more on petitioner's subjective complaints than on the credible objective evidence, and given petitioner's history of symptom magnification the arbitrator finds this troubling. The arbitrator also notes that Dr. D'Souza could not opine that petitioner has a syndesmotic injury, and stated that if the osteochondral lesion was petitioner's only problem he would not recommend surgical intervention to fix the problem. Given that there is no credible diagnostic evidence to support a finding that petitioner has a syndesmotic injury the arbitrator finds the surgery recommended by Dr. D'Souza is not reasonable or necessary.

Based on the above as well as the credible evidence the petitioner's claim for prospective medical treatment in the form of an examination under anesthesia with the possibility of unconfirmed additional surgical procedures by Dr. D'Souza is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

- [x] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [ ] PTD/Fatal denied
- [ ] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission,
Insurance Compliance Division,
Petitioner,

vs. No. 10 INC 00592

14IWCC0295

David L. Greer, Individually & President, and JW Berry, Individually & Secretary, d/b/a/ Big D Enterprises, Inc., d/b/a Desperado's Lounge,
Respondents.

DECISION AND OPINION REGARDING INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Division, brings this action, by and through the office of the Illinois Attorney General, against the above-captioned Respondents, alleging violation of Section 4(a) of the Illinois Workers' Compensation Act. Proper and timely notice was provided to Respondents David Greer and JW Berry, and a hearing was held before Commissioner Donohoo in Mt. Vernon, Illinois on November 14, 2013. Respondents did not appear, and the hearing proceeded *ex parte*.

Petitioner alleged that Respondents knowingly and willfully lacked workers' compensation insurance coverage from October 3, 2007, through April 5, 2011, which is 1,280 days. Petitioner sought a fine of $500.00 per day or $640,000.00. Respondents' last annual premium for workers' compensation insurance was $1,018.00, which equates to $2.79 per day. The daily rate times 1,280 days equals $3,571.20, so the total fine for non-compliance sought by Petitioner was $643,571.20. The Injured Workers' Benefit Fund paid out $4,803.73 to Respondent's injured worker, DeLynn Willett, pursuant to the Commission's July 27, 2012 Decision, which reversed Arbitrator Nalefski's denial of the claim.

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After considering the entire record, the Commission finds that Respondent knowingly and willfully violated Section 4(d) of the Act and Section 7100.100 of the Rules Governing Practice before the Illinois Workers' Compensation Commission for a period of 299 days, from June 12, 2010, the date of Ms. Willett's accident, through April 6, 2011, the date Respondent obtained workers' compensation insurance coverage. The Commission finds that, as a result of Respondent's non-compliance, he shall be held liable and pay the following: (1) a fine of $100.00 per day for every day of non-compliance or $29,900.00; (2) the amount of premium saved by Respondent's non-compliance, $2.79 per day for 299 days, or $834.21; (3) plus the amount paid out to Ms. Willett by the Injured Workers' Benefit Fund, $4,803.73, for a total fine of $35,537.94, pursuant to Section 4(d) of the Act and Section 7100.100(b)(1)(2) of the Rules for the reasons set forth below:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Petitioner presented Joseph Stumph, an investigator for the Insurance Compliance Division of the Illinois Workers' Compensation Commission, as a witness at hearing before Commissioner Donohoo on November 14, 2013.

2. Investigator Stumph testified that he checked Big D Enterprises in INCI and other relevant databases and found no current insurance. An inquiry in the POC database showed no coverage from October 3, 2007 to April 6, 2011.

3. On February 28, 2011, Petitioner issued a Notice of Non-Compliance, demanding proof of Workers' Compensation insurance. A Notice of Insurance Compliance Hearing followed on March 28, 2011, setting a hearing date for November 14, 2013. PX2. Respondent Greer phoned Investigator Stumph and advised him that he had purchased the business in September 2006; he denied having any employees and stated that Ms. Willett was drunk, engaged in horseplay, and was not on duty when she fell behind the bar on June 12, 2010, breaking her right wrist in two places.

4. Respondents subsequently obtained insurance, effective April 6, 2011 through April 6, 2012.

5. On July 14, 2011, DeLynn Willett and Respondents tried her injury case before Arbitrator Nalefski in Herrin, Illinois. PX4. Arbitrator Nalefski issued his decision on September 6, 2011, denying Ms. Willett's claim for failure to prove her employee status at the time of accident. The Arbitrator found that although Ms. Willett was employed as manager/bartender of Respondent, she failed to prove that she was on duty at the time of her injury or that she was not engaged in horseplay, so that her injury did not arise out of her employment as bartender.

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6. On September 27, 2011, Respondent Greer agreed to a $6,000.00 fine for non-compliance with Section 4(d) of the Act, payable at $500.00 per month for one year, and to accept liability for Petitioner's workers' compensation benefits related to her wrist injury. PX3. Respondent made payments to the State of $500.00 on November 1 and November 25, 2011, but failed to make any other payments.

7. Ms. Willett appealed the denial of her injury claim to the Commission, which issued its Decision on July 27, 2012, reversing Arbitrator Nalefski's denial. The Commission found that, although Ms. Willett was not scheduled to work the night of June 12, 2010, she was called in to assist the bartender. She slipped on water underneath the sink and fell onto her right hand, resulting in a compound fracture. Respondents argued that Ms. Willett was intoxicated and engaged in horseplay at the time of her injury. The Commission found there was no reliable evidence that Petitioner was drinking or involved in horseplay and awarded her medical expenses and 7.5% loss of use of the right hand. PX5. Neither party appealed the Commission decision.

8. Investigator Stumph testified that Respondent Greer closed the business in February 2012; its workers' compensation insurance was cancelled on February 18, 2012 for nonpayment of premiums. PX6.

9. On October 23, 2013, Investigator Stumph received a phone call from Respondent Greer, who stated he had received notice of the review hearing, but was very ill, almost blind, and could not attend. Stumph advised Respondent Greer that the hearing would proceed on November 14, 2013, whether or not he was present. Neither Respondent Greer nor Respondent Berry appeared at hearing before Commissioner Donohoo.

Section 4 of the Act, providing for penalties and fines for non-compliance, was codified July 1, 2005. The Commission finds that Respondents are subject to the Act as employers. Section 4 of the Act requires all employers within the purview of the Act to provide workers' compensation insurance for the protection of their employees. The Commission finds that Respondents were in violation of Section 4(d) of the Act for a period of 299 days, from June 12, 2010, the date of accident, through April 6, 2011, the date Respondents obtained workers' compensation insurance coverage.

The Commission further finds that Respondents willfully and knowingly failed to acquire workers' compensation insurance for 299 days after receiving notice of non-compliance. It is evident that Respondents were aware that they were operating a business without the workers' compensation insurance coverage required by the Act. After reviewing all of the evidence, the Commission finds that Respondents did not provide a persuasive reason for their failure to obtain workers' compensation insurance after a notice of non-compliance was issued. The Commission also notes that Respondent Greer entered into a settlement agreement with the State for $6,000 plus the cost of Petitioner's benefits due under the Act, and paid only $1,000 before defaulting on the agreement. Therefore, the Commission orders Respondents to pay $100.00 per day for

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every day of non-compliance with the Act, or $29,900.00; plus the amount of the premium saved by Respondents' non-compliance, $2.79 per day for 299 days, or $834.21; plus the amount paid out to Ms. Willett by The Injured Workers' Benefit Fund, $4,803.73, for a total fine of $35,537.94. Respondents shall receive credit for the $1,000.00 paid toward the settlement agreement, leaving $34,537.94 due and owing.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents, David Greer and JW Berry, individually and as officers, doing business as Big D Enterprises, Inc. and Desperado's Lounge, pay to the Illinois Workers' Compensation Commission the sum of $34,537.94, as provided in Section 4(d) of the Act and Section 7100.100(b)(1)(2) of the Rules.

Bond for the removal of this cause to the Circuit Court by Respondents is hereby fixed at the sum of $35,000.00. The Party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 2 4 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

drd/dak
r-11/14/13
68

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Harold Flynn,
Petitioner,

vs.

NO. 11 WC 01237

14IWCC0296

Cerro Flow Products, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering, the issues of temporary total disability, causal connection, prospective medical expenses and penalties and attorneys' fees and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on March 14, 2013 is hereby affirmed and adopted.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 2 4 2014

David R. Donohoo

Daniel R. Donohoo

Kevin W. Lamborn

o-02/25/14
drd/wj
68

14IWCC0296

DISSENT

I respectfully dissent from the majority who affirmed and adopted the decision of Arbitrator Granada, which held Petitioner failed to meet his burden of proof regarding the issue of causal connection between Petitioner's psychiatric and psychological condition and his accident of January 5, 2009. Petitioner, who had worked for Respondent for 25 years as an electrical supervisor, slipped and fell on oil while walking toward a furnace on January 5, 2009. He sustained injuries primarily to his lower back, and also complained of neck and right shoulder pain. Petitioner was able to perform all of his work activities without issue up to the date of the accident. He was responsible for the electrical and telephone systems of the entire plant. In addition to supervising the electricians of the plant, his duties required him to stand, walk, twist, turn, push, pull, bend, stoop, lift, carry, crawl and climb on cranes and ladders. He had no prior injuries to his back or neck, and no prior history of depression or psychological treatment.

Petitioner sought medical treatment shortly after his work related injury. On March 17, 2009, Petitioner saw Dr. Rutz, an orthopedic surgeon, for a spinal consultation in conjunction with his back and neck problems. Petitioner testified he began experiencing depression within the first two months following the accident. He reported his depression to his treating physician, Dr. Rutz. However, Dr. Rutz was concentrating on his back problems. Over the course of nearly three years, he performed a total of three surgeries on Petitioner's lower back, fusing L3-S1. Dr. Rutz never placed him at maximum medical improvement or released him from low back care. Dr. Rutz has yet to initiate any treatment of the neck.

In September 2011, Petitioner testified he attempted to return to work with significant limitations and restrictions of four hours a day, per Dr. Rutz's orders. Petitioner testified that on October 4, 2011, while attempting to work a four hour day within Dr. Rutz's restrictions, he was suffering from severe pain and depression. Petitioner testified that on that date he "just lost it." He was teary eyed, could not think, felt like life was over and was in extreme and unrelenting pain. Petitioner stated that while he was only expected to perform sedentary work, he simply could not work or concentrate due to the severe fatigue, depression and pain.

On that same day, Petitioner's wife secured an appointment for him to see his primary care physician, Dr. Hollie. Dr. Hollie examined him, diagnosed acute stress reaction, referred Petitioner to pain management and took him off work. As a result of his condition, Petitioner was unable to attend the functional capacity evaluation, which was scheduled for the following day. Petitioner contacted Dr. Rutz's office and was told to call back after he was doing better and they would reschedule the functional capacity evaluation. They did not reschedule it. Subsequently, all medical benefits were eliminated by the workers' compensation carrier. Petitioner made multiple attempts to return to Dr. Rutz for treatment, as well as, to reschedule the functional capacity evaluation. However, all attempts were denied.

On October 17, 2011, Dr. Hollie issued a report, which among other conditions, noted that Petitioner's once-controlled hypertension was now uncontrolled due to his pain and mood disturbances. Multiple requests were made to Respondent to provide Petitioner treatment as requested by Dr. Hollie. Yet, Petitioner never received the necessary treatment.

In light of his declining condition, on January 17, 2012, Petitioner was referred to Dr. Stillings by his attorney for a psychiatric Section 12 exam. Dr. Stillings is a practicing board certified psychiatrist. In addition to his private practice, Dr. Stillings does independent psychiatric examinations in workers' compensation matters on behalf of both petitioners and respondents. Notably, Dr. Stillings testified that on several occasions he has provided Section 12 exams and testified on behalf of respondents' insurance carriers. Dr. Stillings testified that at the time of his evaluation, Petitioner complained of severe low back pain, rating it 7-10/10. He reported sleeplessness, poor appetite, a 50 pound weight loss, spontaneous crying spells, insomnia, poor concentration, fatigue, feelings of helplessness, worthlessness, and thoughts that life was not worth living. Dr. Stillings testified that he performed psychiatric testing. In addition to revealing anxiety and depression, the testing also showed a high degree of psychological distress and a low degree of psychological efficiency. He stated that Petitioner had experienced "serious personality deterioration." Dr. Stillings further found Petitioner's condition to be poor; he had cognitive impairment, disorganized thinking and slow mental processing speed. These were all symptoms of Petitioner's clinical depression. Based on Dr. Stillings' review of the medical records, deposition testimony, testimony of Petitioner's primary care physician, the history provided by Petitioner, as well as, the psychological testing and mental status examination, Dr. Stillings opined Petitioner's current condition was *causally related* to the January 5, 2009, work injury. He diagnosed Petitioner with a mood disorder and a pain disorder. Dr. Stillings stressed Petitioner had no preexisting psychiatric problems. Dr. Stillings testified Petitioner was unable to work due to his psychiatric condition. Dr. Stillings concluded that Petitioner "absolutely" required aggressive psychiatric treatment.

Petitioner saw Dr. Hollie again on March 9, 2012. Dr. Hollie noted that Petitioner's condition was "worsening." Petitioner's weight was now down to 147 pounds. Again on May 23, 2012, Dr. Hollie's notes reflect continued complaints of back pain, sleep disturbance and decreased concentration. He testified that Petitioner had always been a "very upbeat, happy-go-lucky guy" and that he had never seen Petitioner so depressed. Noting Petitioner's blood pressure was out of control, Dr. Hollie opined this was a result of the pain and that Petitioner was unable to work.

But for the appeal process and the ability to scribe a dissent, this case illustrates the utter breakdown in the system. Despite uncontradicted and unrebutted evidence to the contrary, the arbitrator erroneously found there was no causal connection between the admitted work accident and the resulting psychiatric/psychological condition of Petitioner. Unlike so many cases that turn on which expert is to be believed, this case has only the testimony of one psychiatric expert witness, Dr. Stillings, a board certified psychiatrist. He is indeed independent as he has previously testified as much for respondents as he has for petitioners. Dr. Stillings opined that Petitioner's current psychiatric condition is causally related to the January 5, 2009 work injury. Dr. Stillings diagnosed Petitioner with a mood disorder and a pain disorder. He noted that Petitioner had no preexisting psychiatric problems. Dr. Stillings testified quite credibly that Petitioner is unable to work due to his psychiatric condition. Dr. Stillings opinion was buttressed by the testimony of Dr. Hollie, Petitioner's primary care physician since 2005. Dr. Hollie repeatedly commented on Petitioner's downward spiral.

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In his depressive state, Petitioner felt he could not attend the functional capacity evaluation, but was told by the orthopedic surgeon office that Petitioner could reschedule it when he was feeling better. That did not happen, the office would not reschedule. All medical and temporary total disability benefits were cut off when Petitioner attempted to reschedule his functional capacity evaluation. The functional capacity evaluation was scheduled by his orthopedic surgeon, who coincidentally was provided by Respondent's insurance carrier. Petitioner was initially referred to this orthopedic surgeon office by Respondent; the office that would not reschedule the functional capacity evaluation. Also from a purely physical/medical view, Petitioner has never reached maximum medical improvement. Petitioner clearly requires additional medical treatment. Respondent obviously erred when it cut off Petitioner's treatment.

Once Petitioner's temporary total disability benefits were cut off, he attempted to apply for short term disability. But Petitioner's condition was viewed as workers' compensation and he was denied. Consequently, Petitioner was getting neither temporary total disability benefits nor short term disability. Petitioner is financially suffering because of Respondent's actions.

Petitioner undoubtedly met his burden and proved that his mental and physical conditions of ill-being are causally connected to his work related injury. Dr. Stillings provided the only and unrebutted opinion regarding Petitioner's psychological issues. He diagnosed Petitioner with several disorders and opined these were a direct result of the work injury. For all of the reasons stated above, I dissent from the majority.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

FLYNN, HAROLD
Employee/Petitioner

Case# **11WC001237**

CERRO FLOW PRODUCTS INC
Employer/Respondent

14IWCC0296

On 3/14/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

HENNESSY LAW FIRM LLC
CYNTHIA HENNESSY
425 N NEW BALLAS RD SUITE 280
ST LOUIS, MO 63141

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
THEODORE J POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Harold Flynn
Employee/Petitioner

v.

Cerro Flow Products Inc.
Employer/Respondent

Case # 11 WC 1237

Consolidated cases: n/a

14IWCC0296

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Herrin, IL**, on **November 14, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Whether Petitioner engaged in any injurious practice**

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FINDINGS

On the date of accident, **January 5, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$105,245.40**; the average weekly wage was **$4,407.90**.

On the date of accident, Petitioner was **62** years of age, *married* with **0** dependent children.

Respondent *has* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Petitioner failed to meet his burden of proof regarding the issue of causal connection between his psychiatric or psychological condition and his accident from January 5, 2009.

Petitioner's claim for TTD benefits are denied.

Petitioner's claim for prospective medical care as they relate to his psychiatric or psychological condition are denied.

Petitioner's Petition for Penalties under Section 19(k) and 19(d) and Petition for Attorney's Fees is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

2/26/13
Date

ICArbDec19(b)

MAR 14 2013

14IWCC0296

Findings of Fact

There is no dispute that the Petitioner was injured while working on January 5, 2009. At the time, Petitioner was an electrical supervisor, whose job duties included the supervision of employees and being responsible for the entire electrical system. Additionally, he would assist electrical workers, which would involve standing, lifting, carrying items and utilizing cranes and ladders. On January 5, 2009, Petitioner slipped and fell, landing on his buttocks. He complained of pain to his right shoulder, neck, low back, radiating down his right leg. Petitioner continued to work for weeks following this incident.

On March 17, 2009, Petitioner saw Dr. Rutz, an orthopedic specialist. On November 20, 2009, Dr. Rutz performed L3-4 and L4-5 decompression and discectomy. The post-operative diagnoses were L3-4 and L4-5 lumbar spine stenosis and lumbar radiculopathy. The surgery relieved Petitioner's leg pain and he was able to return to light duty work three weeks later with a 20-pound lifting restriction. Petitioner later continued to experience leg and back pain. On February 11, 2010, an MRI revealed grade one retrolisthesis of L3, L4 and L5 unchanged. Noting that his leg pain had returned, Dr. Rutz planned to perform an L3-5 revision decompression and TLIF. This surgery was performed on April 7, 2010. Dr. Rutz allowed Petitioner to return to sedentary duty on June 14, 2010. Reporting low back pain with prolonged sitting, Mr. Flynn was restricted to work only four hours a day. On August 15, 2010, Petitioner reported pain and numbness in his lower back, radiating to his anterior thighs. Dr. Rutz ordered a CT myelogram. The myelogram showed an L2-3 retrolisthesis with broad-based disc bulge, facet arthropathy, and ligamentous hypertrophic changes, resulting in moderate central canal stenosis and moderately severe bilateral neural foraminal encroachment. Petitioner then had a third surgery. On November 17, 2010, Dr. Rutz performed an L2-3 TLIF with a prosthetic inter-body device, removal of posterior instrumentation at L3-4, placement of posterior instrumentation L2-3, L3-4, and L4-5, posterior fusion at L2-3, and right iliac crest bone grafting. Petitioner followed up with Dr. Rutz on December 2, 2010 and reported his leg pain was gone.

James Coyle, M.D. conducted an IME on behalf of the Respondent on July 20, 2011. Noting multiple potential sources of pain, Dr. Coyle opined Mr. Flynn was incapable of working in more than a very sedentary capacity with intermittent sitting and walking and no significant lifting.

Petitioner followed up with Dr. Rutz on September 13, 2011 and reported progressively increasing back pain. Dr. Rutz noted that the facet blocks did not provide any improvement to his back pain. Dr. Rutz ordered an FCE and told Petitioner he could work four- hour days in a sedentary capacity, and instructed him to return to the office following the FCE.

Petitioner did not attend the FCE and testified that he tried to re-schedule the IME. Dr. Rutz testified that Petitioner did not attend the follow-up appointment scheduled after the FCE. Dr. Rutz opined that Petitioner was close to being at MMI as of September 29, 2011. Petitioner testified that he tried to return to work in September, 2011 with the restrictions of a four hour work day in a sedentary capacity, but he felt depressed and pain.

Instead of returning to Dr. Rutz, Petitioner saw his primary care physician, Dr. Hollie. He complained of poor appetite, weight loss, depression, and anxiety. Dr. Hollie took Petitioner off work, referred him to pain management and diagnosed weight loss, acute stress reaction and sleep disturbance. On October 17, 2011, Dr. Hollie issued a report stating that Mr. Flynn was suffering from an acute stress reaction and

14IWCC0296

sleep disturbances resulting in weight loss, attributing it to the pain incurred as a result of the back injuries and ensuing surgeries.

On referral by his attorney, Petitioner saw Dr. Stillings for a psychiatric consultation on January 17, 2012. Dr. Stillings diagnosed Petitioner with a mood disorder and a pain disorder – both of which he opined was related to his January 5, 2009 work accident. He further opined that the Petitioner was totally disabled as a result of his psychiatric conditions.

Petitioner testified that he no longer enjoys his outdoor hobbies of fishing, hunting or working on his own cars. He confirmed that although he is still an employee of the Respondent, he cannot work there because of his depression, inability to focus and his complaints of pain.

On cross-examination, Petitioner confirmed that he did not receive any referrals for psychiatric treatment from Dr. Rutz, Dr. Hollie or Dr. Coyle.. He further confirmed that the first psychiatric treatment with Dr. Stilling was arranged through his attorney. Petitioner also admitted that he has been able to shoot deer from his window, despite his inability to hunt. Respondent also offered into evidence a video showing Petitioner spending time at a Mercedes Benz dealership, where he is seen socializing, eating and having some refreshments.

Based on the foregoing, the Arbitrator makes the following conclusions:

1. Petitioner failed to meet his burden of proof regarding the issue of causation as it relates to his alleged psychiatric condition. While there is no doubt that the Petitioner sustained a serious injury involving his back that required 3 surgeries, the Petitioner's psychiatric condition of depression and anxiety was never raised by his treating physicians or the Respondent's IME in almost three years following his accident. The Arbitrator notes that Petitioner's psychiatric condition did not become a debilitating condition until he was on the verge of being placed at MMI by his own treating physician, Dr. Rutz. In fact, when Dr. Rutz ordered an FCE to determine Petitioner's ability to return to work, Petitioner did not attend the FCE and instead went to his primary care physician, who noted among other various conditions, an "acute stress reaction." And instead of being referred for psychiatric treatment by any of his treating physicians, the Petitioner was referred by his attorney to Dr. Stillings for a psychiatric IME in what appears to be a not-so-subtle attempt to establish permanent total disability based on a psychiatric condition. It bears repeating that the Petitioner's psychiatric condition did not become a bar to returning to work until Petitioner was sent for an FCE by his own treating orthopedic surgeon. All of these facts, lead the Arbitrator to conclude that there is a serious lack of credibility on the part of the Petitioner regarding the issue of causation.

2. Petitioner failed to prove he is entitled to TTD beyond September 29, 2011. Again, the Arbitrator questions the Petitioner's credibility on this issue based on the dubious timing of events. In this case, Petitioner was scheduled by his own treating orthopedic surgeon, Dr. Rutz to undergo an FCE to determine what, if any, work Petitioner could possibly perform. Petitioner chose not to attend the FCE and instead went to his primary care physician with complaints of anxiety, depression, etc. Petitioner is then taken off work based on these psychiatric complaints, despite the fact that the primary care physician does not make any referral for psychiatric treatment. Petitioner does not return to Dr. Rutz, who had been treating him for his back condition for years, and instead goes to see a doctor referred by his attorney for a psychiatric IME. The Arbitrator also notes the blaring

inconsistencies between what the Petitioner testified he could not do, and what was revealed on cross-examination. This includes the ability to shoot deer from his kitchen window, despite Petitioner's testimony that he could no longer hunt. Also, the Petitioner claimed he could not sit for longer than 20 minutes, yet he was able to sit through the arbitration hearing that lasted well over an hour, as well as drive the long distance from his home in Missouri to the hearing site. Petitioner is also seen a number of times socializing at a Mercedes Benz dealership, which is in stark contrast to his testimony that made it sound like he was relegated to spending all day on his back. Based on the lack of credibility, the Arbitrator denies the Petitioner any TTD beyond September 29, 2011, which is the date Petitioner's treating physician, Dr. Rutz testified the Petitioner was near MMI. Because of the Petitioner's credibility issues, it is difficult to determine if the Petitioner is entitled to any TTD.

3. Based on the findings above, the Petitioner's request for prospective medical care as it relates to his psychiatric condition is hereby denied.

4. The Petition for Penalties and Attorney's fees is denied, based on the findings above.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kent McFall,

Petitioner,

14IWCC0297

vs.

NO: 12 WC 39335

The Sygma Network, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the sole issue of nature and extent, modifies the Decision of the Arbitrator as stated below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In his Statement of Exceptions, Petitioner argues that the Arbitrator "failed to fully address the nature and extent of Petitioner's injury" and asks the Commission to modify the permanency award to be more consistent with prior Commission decisions. After a complete review of the record, the Commission finds that the Arbitrator did fully address the full nature and extent of Petitioner's injury and awarded permanency benefits based on the evidence provided and the American Medical Association (hereinafter "AMA") guidelines, as required by the Workers' Compensation Act (hereinafter "Act"). However, the Commission finds that Petitioner suffered a greater degree of permanent disability than assessed by the Arbitrator.

As noted by the Arbitrator, Petitioner's accident occurred after the September 1, 2011 changes to the Act establishing the following criteria for the determination of permanent partial disability:

> "(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of

> medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.
>
> (b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order." 820 ILCS 305/8.1b (2013)

In his Statement of Exceptions, Petitioner lists several Commission decisions by which claimants with a neck injury who underwent fusion surgery were awarded between 20% and 35% loss of use of the person as a whole. These Commission decisions are, as are the AMA guidelines, simply one more component to consider in deciding the issue of permanent disability. In determining Petitioner's permanent disability, we must, as did the Arbitrator, consider each part of Section 8.1b of the Act, as well as the evidence provided at hearing and prior Commission decisions.

In following the criteria laid out in Section 8.1b, the Commission notes that:

- Petitioner's treating physician, Dr. Stephanian, found, per the AMA guidelines, that Petitioner was "doing extremely well" and had "complete resolution of the pain in his neck, shoulder and arm" with only "very minimal and occasional discomfort at the base of the neck." (RX1) Petitioner reported during that November 16, 2012 visit that he had "marked improvement in his strength as well as range of motion." Dr. Stephanian found that Petitioner had "had a nice outcome from his recent anterior cervical interbody fusion" and released Petitioner to return to work without restrictions.

  During a prior visit, on October 19, 2012, Dr.

Stephanian declared Petitioner to be at maximum medical improvement and determined that Petitioner "has approximately a 10% impairment of the whole person for this particular injury based on standard AMA guidelines." (PX3,RX2) Dr. Stephanian released Petitioner to return to work without restrictions and indicated that Petitioner is "able to drive commercial vehicles with no issues. Able to do line haul work."

- Petitioner returned to work as a truck driver, the same job he held, pre-accident, with Respondent. (T.14, 32)

- Petitioner was 41 years old at the time of the accident. (AX1, AX3)

- Petitioner testified that he continues to have left arm pain and loss of strength and continues to take pain medication. (T.33, 35) However, Dr. Stephanian specifically found that Petitioner's "residual aches and pains in the arms...are unrelated to the surgery" and suggested that Petitioner might want to see a rheumatologist "at some point in the future to look into this further." (PX3, RX2) Furthermore, Petitioner admitted that the pain medications he takes are from his 1st surgery, which was for his low back and is unrelated to the March 15, 2012 accident. (T.35) This is further supported by the medical records which indicate that Petitioner was taking these medications before the March 15, 2012 accident. (PX1) Finally, as mentioned earlier, on November 16, 2012, Dr. Stephanian specifically found that Petitioner's neck, shoulder and arm symptoms had completely resolved. (RX1)

The Commission further notes that while Petitioner's neck pain has resolved overall, during his last visit with Dr. Stephanian, Petitioner was still complaining of "occasional discomfort at the base of the neck." (RX1) And while Petitioner has been able to return to work as a truck driver, his pre-accident occupation, he admitted that he now drives shorter distances as a truck driver for a new employer. (T.33) Finally, the Commission notes that Petitioner continues to take pain medication, and while it is the same pain medication he was taking prior to the March 15, 2012 accident for an unrelated low back issue, Petitioner also takes it for his occasional neck symptoms. (T.33, 35) Considering the substantial neck injury Petitioner suffered, the fact that he had to undergo a C7-T1 fusion surgery with instrumentation, that he has returned to work without restrictions, that he continues to suffers from occasional neck symptoms, and the amounts traditionally awarded in cases such as these, the Commission finds that Petitioner suffered a 22-1/2% loss of use of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the

14IWCC0297

Arbitrator filed on October 18, 2013, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $492.51 per week for a period of 112.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 22-1/2% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $55,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 2 8 2014
MJB/ell
o-04/08/14
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0297

McFALL, KENT
Employee/Petitioner

Case# 12WC039335
13WC000294

THE SYGMA NETWORK INC
Employer/Respondent

On 10/18/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1608 MOSS & MOSS PC
DAVID MOSS
122 WARNER CT PO BOX 655
CLINTON, IL 61727-0655

2965 KEEFE CAMPBELL & BIERY ASSOC LLC
JOHN CAMPBELL
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

14IWCC0297

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

KENT MCFALL
Employee/Petitioner

v.

THE SYGMA NETWORK, INC.
Employer/Respondent

Case # **12** WC **039335**

Consolidated cases: **13 WC 000294**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana, Illinois**, on **August 22, 2013**. By stipulation, the parties agree:

On the dates of accident, March 15, 2012 and April 9, 2012, Respondent was operating under and subject to the provisions of the Act.

On these dates, the relationship of employee and employer did exist between Petitioner and Respondent.

On these dates, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of the accidents was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accidents.

In the year preceding the injuries, Petitioner earned **$46,684.00**, and the average weekly wage was **$820.85**.

At the time of the injuries, Petitioner was **41** years of age, ***married*** with **1** dependent child.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

In 13 WC 000294 (D/A: 4.9.12) Respondent shall be given a credit of **$14,228.76** for TTD, **$255.38** for TPD, **$0** for maintenance, and **$0** for other benefits. With regard to that case Petitioner was temporarily totally disabled from **4.22.12 to 10.20.12** (a period of 26 weeks) and temporarily partially disabled from **4.17.12 to 4.21.12** (a period of 5/7 weeks).

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$492.51**/week for a further period of **87.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **17.5% permanent loss of use of the man as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **March 15, 2012** through **August 22, 2013**, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

October 14, 2013
Date

ICArbDecN&E p.2

OCT 18 2013

These cases were consolidated at the time of arbitration and the attorneys requested that one decision issue for both cases.

The Arbitrator finds:

Petitioner began working for Respondent on January 5, 2009. Petitioner is employed as a truck driver. Petitioner testified that his job duties involve driving a semi-tractor trailer rig as an over-the-road truck driver.

Petitioner testified that on March 15, 2012 (12 WC 39335), he was getting out of his truck when he tripped over computer wires which were running through his truck cab, and he fell out of the cab, a distance of approximately 5 ½ feet, landing on his left side and left shoulder. At that time, Petitioner experienced a burning sensation and pain between his shoulder blades. Petitioner testified that he gave notice of this incident to Mike Durant. Petitioner testified that he continued to work his regular job duties following this incident. There was no medical treatment incurred as a result of this incident.

Petitioner testified that as he continued to work, he also continued to notice pain.

On April 9, 2012, (13 WC 000294), Petitioner, while in Indianapolis, was reaching up to open trailer doors. As Petitioner was opening the trailer doors, he experienced extreme pain down his left arm. Petitioner called Respondent and reported this incident. Following his call to Respondent, Petitioner drove from Indianapolis, Indiana to Danville, Illinois. On April 9, 2012, Petitioner was seen at Carle Clinic in Danville, Illinois. At that facility, Petitioner was seen by Dr. Allison Jones, M.D., through the Occupational Medicine Department (PX 1). Petitioner was released to modified work and told to use a TENS Unit, which he had from a prior back surgery. Petitioner was also prescribed physical therapy at UAP Clinic.

Physical therapy commenced at UAP Clinic on April 13, 2012. On April 16, 2012, Petitioner returned to Dr. Jones. At that time, modified work was continued and an MRI was prescribed. (PX 2)

On April 23, 2012, Petitioner was seen by Dr. Chen. Dr. Chen renewed the prescription of an MRI and instructed Petitioner to not work. The MRI was performed on May 3, 2012. In follow up on May 10, 2012, Dr. Chen interpreted the MRI as revealing a large herniated nucleus pulposus at C7-T1, and a central protrusion at C5-C6 or C6-7[1]. Petitioner was prescribed to be off work. Petitioner was also prescribed an injection. Petitioner underwent an epidural steroid injection at that time. In follow up on July 12, 2012, Petitioner was continued off work and received his second epidural steroid injection. (PX 2)

On August 17, 2012, Petitioner was again seen by Dr. Chen, who continued to assess neck pain and noted a disc herniation at C6-C7 and C7-T1. Petitioner was continued off work. Physical therapy was prescribed at Union Hospital. Physical therapy began September 25, 2012.

Petitioner was referred by Dr. Chen to Dr. Stephanian (PX 3) Petitioner was initially seen by Dr. Stephanian on August 30, 2012. At that time, Petitioner was prescribed surgery for a herniated disc at C7-T1. On September

[1] The MRI report states C6-7 in the Findings; C5-6 in the Impression. (PX 3)

12, 2012, Petitioner underwent an anterior cervical microdiscectomy at C7-T1, interbody fusion with allograft bone, anterior spinal instrumentation with Orion plate. The surgery was performed at Union Hospital and there were no complications. (PX 2) Petitioner followed with Dr. Stephanian on September 21, 2012. At that time, Petitioner was released to return to work light duty restrictions and prescribed physical therapy. Follow-up examinations were performed through October 2012. At the time of the October 12, 2012 appointment Petitioner was still experiencing severe pain in both his arms. Petitioner described it as diffuse pain bilaterally and did not associate the pain with any joints or experience any numbness or subjective weakness. There was no evidence of infection on examination. Petitioner's neck range of motion was good and his upper limbs were noted to have excellent strength and no sensory deficits. Reflexes were normal throughout. Recent x-rays showed no problems. Authorization for an MRI was pending. Dr. Stephanian could not explain the etiology of Petitioner's complaints but did not attribute them to his recent operation. Petitioner appeared neurologically intact and the doctor noted a referral to a rheumatologist might be appropriate. (PX 3)

Another cervical MRI was performed on October 13, 2012 due to ongoing complaints of neck pain and bilateral arm soreness. It revealed post-operative changes and mild spondylosis with mild left foraminal compromise at C5-6 and might right foraminal compromise at C4-5. (PX 3) A note on Dr. Stephanian's copy of the MRI report states "MRI reviewed. Looks good. Patient advised 10/16/12 may need referral to [rheumatologist]. Patient to call if wants appointment." Petitioner was also advised his labwork was good and that if he wished to go to a rheumatologist, it would no longer be "work comp." (PX 3)

When re-examined on October 19, 2012, Petitioner reported some mild residual aches and pains in both arms but complete resolution of his radicular left arm pain. Petitioner also reported a marked improvement in the strength of his left arm and hand. He had completed a full course of postoperative therapy which had been of marked benefit. Dr. Stephanian remarked that Petitioner had a "good outcome" from his surgery and he noted Petitioner's residual aches and pains in his arms were unrelated to Petitioner's prior surgery. He recommended Petitioner consider a consultation with a rheumatologist regarding those complaints. Dr. Stephanian also indicated Petitioner was able to drive commercial vehicles with no issues and could perform line haul work. (PX 3) On October 19, 2012, Dr. Stephanian found Petitioner to be at maximum medical improvement and rendered a 10% man as a whole impairment based on "standard AMA guidelines." (PX 3)

Petitioner returned to Carle Clinic for a DOT Fitness Determination on October 25, 2012 at which time he received his certificate valid through October 25, 2013. (PX 1)

In a final follow-up visit with Dr. Stephanian on November 16, 2012, Petitioner was noted to be doing "extremely well" with complete resolution of his neck, shoulder, and arm pain with marked improvement in his strength and range of motion. Occasional discomfort at the base of his neck was noted. Petitioner was allowed to return to work with no restrictions. (RX 1)

Petitioner testified that, in fact, he did return to his regular job duties driving for Respondent.

Petitioner also testified that he was unable to work from March 2012, through May 22, 2012, due to a cardiac condition. Petitioner testified that he did not consider the cardiac condition to be an element of this workers' compensation claim. On May 22, 2012, after his heart attack, Petitioner left the employment of Respondent and began working at Schopmeyer Farm Supply. Petitioner testified that he is driving trucks for this company. Petitioner drives shorter distances now; otherwise, his job duties remain unchanged. Petitioner testified that he continues to experience loss of strength in his arms, especially the left one. He also testified to daily pain/discomfort.

Petitioner testified that he has not received any medical bills and that all medical bills have been paid. Petitioner received temporary partial disability for the period April 17, 2012, through April 21, 2012. Petitioner received temporary total disability for the period April 22, 2012, through October 20, 2012 (RX 3).

Regarding the nature and extent of Petitioner's injury, the Arbitrator concludes:

Petitioner's accidents occurred on March 15, 2012 and April 9, 2012. As such, the claims are subject to Section Sec. 8.1b of the Illinois Workers' Compensation Act, which provides that for accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (Source: P.A. 97-18, eff. 6-28-11.)

In accord with Section 8.1b of the Act, the Arbitrator has considered the following factors when reaching her decision regarding the issue of permanency:

(i) The reported level of impairment pursuant to subsection (a):

Dr. Stephanian, Petitioner's treating surgeon, issued an impairment rating of 10% MAW based on "standard AMA guidelines." There is no mention of a QDash report in his October 19, 2012 office note wherein he expressed his opinion on the impairment rating. The office note contains no specific measurements as described in paragraph (a) of Section 8.1b. Rather, Petitioner's range of motion is described as "excellent," his strength as "good," and triceps and hand strength is "mark[edly improved.]." (PX 3) Dr. Stephanian did not indicate whether or not he used the 6th edition of the AMA Guides.

(ii) The occupation of the injured employee:

Petitioner returned to work at his pre-injury occupation as a truck driver.

(iii) The age of the employee at the time of the injury:

Petitioner was 41 years of age at the time of his injuries. While young, no evidence was presented as to how Petitioner's age might affect his disability.

(iv)The employee's future earning capacity:

Petitioner returned to his pre-injury occupation of a truck driver and no evidence was presented as to how Petitioner's injury might affect his future earning capacity. Petitioner has been able to find other employment as a truck driver with no indication of a negative impact on his earning capacity.

(v) Evidence of disability corroborated by the treating records:

After undergoing epidural steroid injections and physical therapy, Petitioner underwent an anterior cervical microdiscectomy at C7-T1, interbody fusion. He was released to return to his regular job with no restrictions and has been working without the need for any further medical treatment since November of 2012. While he initially returned to work for Respondent he voluntarily found employment with another employer in the same line of work. While Petitioner testified to occasional discomfort in his arm, Dr. Stephanian advised Petitioner that such discomfort was unrelated to his back surgery.

The Act provides that no single enumerated factor shall be the sole determinant of disability. While Petitioner has undergone surgery, he has no permanent work restrictions and there is no evidence of reduction in his earning capacity or suggestion of a hindrance to his earning capacity as a result of his injury. By all accounts, Petitioner has had a very good outcome with Dr. Stephanian noting "complete resolution of the pain in his neck, shoulder, and arms." (PX 3) Petitioner's ongoing complaints of occasional arm discomfort, however, do not appear to be related to his injury.

On the basis of the foregoing, the Arbitrator awards Petitioner 17.5% loss of use of the man as a whole, pursuant to Section 8(d)2 of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $492.51 a week for 87.5 weeks because the injuries sustained caused the 17.5% loss of a man as a whole as provided in Section 8(d)2 of the Act.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKER COMPENSATION COMMISSION

Ron Mullenix,
Petitioner,

Vs.

14IWCC0298

NO: 11 WC 18990

Berglund Construction,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, permanent disability, and medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 1, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 2 8 2014

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB:bjg
0-4/8/2014
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0298

MULLENIX, RON
Employee/Petitioner

Case# **11WC017522**
11WC018990

BERGLUND CONSTRUCTION
Employer/Respondent

On 8/1/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4129 WOLFE LAW PC
KENNETH WOLFE
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

2337 INMAN & FITZGIBBONS LTD
JACK SHANNAHAN
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

14IWCC0298

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ron Mullenix,
Employee/Petitioner

v.

Berglund Construction,
Employer/Respondent

Case # **11** WC **17522**

Consolidated cases: **11 WC 18990**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Chicago**, on **6/12/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

14IWCC0298

FINDINGS

On **10/12/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$75,296.00**; the average weekly wage was **$1,448.00**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **no** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**.

Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $669.64 per week for 10 weeks, because the injuries sustained caused the 2% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

7/31/13
Date

ICArbDec p. 2

AUG 1 - 2013

STATEMENT OF FACTS:

Petitioner, a 54 year old laborer foreman and safety champ, testified that he had been hired by Respondent in 1989. Petitioner indicated that his job duties including walking around the construction perimeter checking proper fencing and signage and making sure that employees were following safety regulations.

Petitioner alleged that he injured his left foot on August 16, 2010. See decision for companion claim 11 WC 18990 for findings of facts and conclusions of law with respect to this alleged left foot incident.

With respect to the current undisputed accident (11 WC 17522) , Petitioner testified that on October 12, 2010, he was working for the Respondent flagging a forklift, while walking down the street, when he was hit from behind by the forklift knocking him to his knees. Petitioner did not seek medical treatment at that time but was already on pain medication for his foot.

Petitioner continued working for the Respondent full-time thereafter, including a lot of overtime, until December 2010. Petitioner testified that he had constant pain in his foot and back at that time. He was taking pain medications while working. Petitioner began a winter layoff in December 2010.

Petitioner continued to treat for his left foot injury thereafter. See decision with respect to claim 11 WC 18990.

With respect to his back, Petitioner noted that it currently still bothers him, especially when he gets up after sitting for a while. He indicated that he did not have these issues with his back prior to the injury in question.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that he had no back problems prior to the accident of October 12, 2010 when he was struck from behind by a forklift, knocking him down. He did not seek medical treatment but was already taking pain medications for his foot injury, which is the subject of the companion case.

He was able to continue working until the end of the season in December. He testified to constant pain in his low back continuing to the present time. He also testified to difficulty standing after sitting for a long time, and pain upon arising in the morning.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's current condition of ill-being with respect to his back is causally related to the undisputed accident of October 12, 2010.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Although Petitioner lost no time from work due to this accident and had no treatment other than pain medication, he did credibly testify to ongoing complaints ever since. Specifically, he testified that his low back hurts when he gets up after sitting for a while and that he had not experienced any such back related complaints prior to the accident.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 2% person-as-a-whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☒ PTD denied
☒ Modify down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GLENDA PERRY,

Petitioner,

vs.

14IWCC0299

NO: 06 WC 15927

SPEEDWAY SUPER AMERICA,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, and permanent partial disability and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission finds that Petitioner failed to prove that she is permanently and totally disabled as the result of her work-related injury of December 15, 2005. The Commission finds that Petitioner sustained sixty-five percent loss of use of the person-as-a-whole as the result of her injuries. All else if affirmed and adopted.

On December 15, 2005, Glenda Perry was employed as a cashier for Speedway. On this date, she was walking from an outside storage shed with an armful of cups and anti-freeze. As she descended the ramp, she slipped on ice and fell onto her back. She had immediate onset of pain in her low back, neck, and right shoulder. Prior to the accident, the Petitioner underwent a performance evaluation on November 15, 2005. Petitioner's work was described as outstanding. However, Speedway wanted Petitioner to be more flexible in her work schedule especially working weekends. PX.28.

Dr. Patrick Sweeney performed a C5-C6 anterior cervical diskectomy and fusion with

kinetic place, peak cage and grafton on November 27, 2006. PX.3.

Dr. Sweeney then performed an L4-L5, L5-S1 right decompressive hemilaminectomies, complete facetectomies and diskectomies on May 14, 2007. Dr. Sweeney also performed an L4-L5, L5-S1 transforaminal lumbar interbody fusion with hourglass cages and an L4-L5 and L5-S1 posterior fusion with pilot instrumentation. PX.3.

Petitioner was seen by Dr. Sweeney on May 24, 2007. She had spasms in her low back and in her lower right extremity. The pain radiated down her right posterior thigh and calf. Her cervical range of motion showed bilateral rotation of 70 degrees, full flexion and extension of 25 degrees. She was at MMI for her cervical fusion. PX.1.

Petitioner underwent an IME with Dr. Andrew Zelby on January 28, 2008. He opined that the herniated discs at C5-C6 were related to her work injury. The cervical surgery was reasonable and necessary and related to her work accident. Her lumbar injury was nothing more than a lumbar strain in the face of modest degenerative disc disease. The lumbar fusion was not reasonable or necessary. Her ongoing complaints and need for treatment were not related to the accident. RX.3.

Dr. Harel Deutsch performed a revision of her lumbar fusion on September 29, 2009. He also performed hardware removal, L3-S1 posterolateral instrumented fusion and autograft removal, and application over spinous and transverse processes. The post-operative diagnosis was L4-L5 pseudoarthrosis and construct failure. PX.2.

Petitioner underwent an FCE at St. Mary's Medical Center on July 6, 2010 that was performed by physical therapist, Tina Doctor. The FCE revealed that Ms. Perry did not complete all the activities required in the FCE. She performed a few static lifts then refused to perform any further lifting tests. Ms. Doctor noted that it was possible Petitioner could have done more than what she stated. The grip strength demonstrated a submaximal and inconsistent effort. She completed 4 out of the 9 levels of lifting. She refused to perform the dynamic lifting due to severe low back pain. She was not able to complete the cardiovascular condition as she was unable to perform the required frequency of steps. She did not perform the carry, push, pull, stoop, crouch and crawl testing. The FCE revealed that Petitioner could perform at the sedentary level. She demonstrated diminished ability to participate in 8 hours of work that required lifting, standing, bending, stooping, kneeling, sitting, climbing and walking with frequent positional changes. The test revealed that she may not be able to perform any lifting during 8 hours of work. However, this was not a full representation of her functional abilities since she was not able to perform all required activities. RX.2. Ms. Perry testified that she could not perform all the activities due to her pain. T.55.

Ms. Perry presented to Dr. Deutsch on July 16, 2010. Her back pain was 3 out of 10 following the surgery. He noted that the Petitioner continued to have some degree of back pain, but her pain had improved dramatically. Dr. Deutsch noted that the FCE indicated some inconsistent effort and difficulty with lifting due to complaints. The FCE found that the Petitioner could work at a sedentary level with 10 pound lifting restrictions. Dr. Deutsch noted that the restrictions were permanent. She was at MMI and was to follow-up in 6 months. PX.4.

Petitioner was seen by Dr. Deutsch on September 3, 2010. She was one year post-op of the revision of her lumbar fusion. She was at MMI and did not need further care or physical therapy. She required continued medication for her ongoing pain. PX.4.

Petitioner underwent an initial vocational rehabilitation with Monika Dabrowiecjka from Forte on November 3, 2010. The case was referred from Triune. Petitioner reported that she enjoyed being active and involved in various activities with her grandchildren. However, she no longer enjoyed those activities due to her injury. She had a GED. She had worked as a waitress, a clerk, a cashier and in daycare. She had previously operated her own daycare for 3 years, but had to close due to emotional attachment to the children. She lacked computer skills. Petitioner reported that she was motivated to seek employment, but was unsure of the type of work for which she would be qualified. The consultant noted Petitioner's employability was limited due to her light duty restrictions and lack of computer skills. She could work in light assembly or cashier positions. PX.10.

Petitioner was seen by Dr. Deutsch on December 13, 2010. She was at MMI and could work at a sedentary level lifting up to 10 pounds. She reported continued neck pain. She was currently looking at unemployment. She wanted the doctor to indicate that she could work in security as sitting was okay for her. She also wanted the doctor to indicate that she could work up to 4 hours and that she continued to be on medication. He prescribed her Flexeril instead of Robaxin. PX.4.

Ms. Perry underwent vocational rehabilitation with Ms. Dabrowiecka. The vocational process was discussed with the Petitioner. A "how to interview" session was held and they discussed her resume. She could work in assembly, desk security, teller, retail such as a cashier and sales positions. The consultant noted that given the restrictions and lack of computer skills, the job market would be limited. The Petitioner reported that she was not qualified to work in assembly due to her neck pain. She also reported that she was not able to work 8 hour days due to her pain, but could manage a 4 hour shift. She also reported that she could not stand in one place for more than 5 to 10 minutes and could not drive long distances. The consultant noted that none of the limitations were prescribed by a doctor. The Petitioner noted that she was going to her doctor on January 28, 2011 and may have additional restrictions. The consultant noted that the restrictions from December 13, 2011 included lifting up to 10 pounds, change positions as needed, avoid ladders, and minimal twisting/bending. Ms. Dabrowiecka noted that the Petitioner was imposing limitations which may not have been documented. The self-imposed limitations may seriously hinder her chances of being selected for employment. PX.10.

Petitioner underwent a CT scan of the lumbar spine on January 28, 2011. The CT scan revealed no evidence of disruption of the hardware since the revision. There was interval placement of bone graft along the posterior elements. There was evidence suggesting some continuity of the L5-S1 disc space and across the posterior elements from L3 through L5. PX.4.

Petitioner was seen by Dr. Deutsch on January 31, 2011. Petitioner was over one year post-op from the L3-S1 fusion. Examination revealed that she wore a back brace and walked well. She had excellent placement of the instrumentation. She was at MMI and the FCE revealed that she could work at a sedentary level lifting up to 10 pounds. Petitioner reported trouble with

prolonged sitting and she had difficulty sitting for more than two hours. She felt that working more than 4 hours would be too difficult. PX.4.

According to the March 1, 2011 vocational report, Petitioner received a call from Instead Senior Care. The counselor contacted the company and it was revealed that Ms. Perry indicated on her application that she was able to work first shift only. Petitioner confirmed this to the counselor and indicated she was willing to work first shift only as she would become tired at the end of the day. PX.10. Petitioner told Ms. Dabrowiecjka that she does not work on Sundays as this is the day she goes to church. T.61.

According to the March 28, 2011 vocational report, Ms. Perry received a call from American Income Life Company for a customer service position. The employer noted the position was full-time and Petitioner noted she could work part-time only. PX.10.

According to the April 25, 2011 vocational report, Petitioner had an interview on April 21, 2011 for a bench assembly position and with ISM security. The employer at ISM security disclosed that Ms. Perry was interviewed; however, he was not able to place her in any of the positions. The employer stated that Petitioner seemed too fragile in order for him to hire her. He noted that Ms. Perry provided too much information voluntarily such as her back injury and her inability to drive due to taking morphine. The employer at Paramount Staffing reported that Petitioner disclosed her back injury on her application. Petitioner was advised to not disclose too much information. According to the May 3, 2011 report, Petitioner stated she was not able to drive while on morphine. The consultant noted that there was no physician that prescribed driving restrictions. PX.10

According to the May 6, 2011 vocational report, Ms. Perry stated she was willing to secure employment, but the counselor noted that Petitioner displayed behaviors that were contradictory to her stated willingness. She continued to self impose limitations which had not been documented by her physician, such as the inability to work second or overnight shift and no driving due to taking morphine. The counselor noted that the Petitioner appeared to sabotage her chances of employment as evidence by the feedback from Paramount Staffing and ISM Staffing. PX.10.

On June 7, 2011, Ms. Dabrowiecka noted Petitioner was asked to attend a job fair on June 8, 2011. The employer reported that desk security/customer service positions were available and the employer would conduct interviews on the spot. Ms. Perry stated that she was not physically able to attend the job fair due to her computer class in the evening and that she was suffering from the stomach flu. Petitioner reported that she could not juggle both activities in one day due to her back pain. PX.10.

On July 1, 2011, Petitioner's attorney referred Ms. Perry to Grzesik and Associates for a vocational rehabilitation assessment. The evaluation was conducted by Thomas Grzesik. He opined that the Petitioner was unable to perform the duties of her pre-injury occupation as a cashier. She was unable to perform work activities of any occupation that she was otherwise qualified to perform. She was unemployable and met the criteria for odd-lot permanent total disability. PX.11.

Mr. Grzesik performed a telephone interview on July 20, 2011. He reviewed the depositions and records from Triune and FCE. He noted that Triune's placement efforts failed. His opinion that she was not employable remained unchanged. She met the criteria for odd lot permanent total disability. PX.11.

According to Forte's vocational report dated August 17, 2011, Petitioner was enrolled in Intro to Computers and a keyboarding class. She had perfect attendance and received a satisfactory grade in computers, but a non-satisfactory grade in keyboarding. The consultant noted that Petitioner's work restrictions with the ability to work a 4 hour shift with additional limitations of no driving due to medication considerably limited her job search. PX.10.

According to the vocational rehabilitation report prepared on September 19, 2011, Mr. Dabrowiecka noted that Petitioner received a non-satisfactory grade in typing as she needed to be able to type 30 words per minute. She was typing at 11 words per minutes. Ms. Dabrowiecka noted that this was considered a major improvement from her lack of typing skills. PX.10.

Ms. Dabrowiecka prepared a vocational progress report on January 12, 2012. The report was for the period of December 10, 2012 through January 12, 2012. It was noted that Petitioner was searching for employment and placing follow-up calls. The report indicated that the consultant asked the Petitioner if she was disclosing her restrictions before inquiring about the position. She was reminded to discuss her qualifications at the interview and ask about requirements first and then accommodations. The report further indicated that Petitioner was looking for work on her own. The consultant contacted 15 employers where Petitioner had submitted an application. Only 3 employers agreed to provide information and all 3 said they received her application. The consultant noted that she verified Petitioner's sheets to verify if the employers were not hiring and the information Petitioner provided was accurate. The consultant noted that the job search was considerably limited due to the sedentary restrictions with the ability to work 4 hour shifts only and no driving. PX.10.

Petitioner was seen by Dr. Deutsch on February 17, 2012. Examination revealed that the neck rotated to 80 degrees in both directions. The cervical paraspinal muscles showed no spasms and were normal in bulk. The Spurling test was negative. She had a negative bilateral straight leg raise. Examination of the lower back revealed no tenderness to palpation. The paraspinal muscles were normal in bulk and her range of motion included flexion up to 90 degrees and extension up to 20 degrees. Her legs demonstrated no tenderness to palpation. She had a solid fusion at L3 to S1. The diagnosis was low back pain and degeneration of lumbar or lumbosacral intervertebral sac. The Petitioner rated her back and leg pain as 5 out of 10. She experienced more pain with activity and with sitting greater than 2 hours. Dr. Deutsch placed her at MMI with permanent restrictions as defined by the FCE. PX.4.

Petitioner was seen by Dr. Satish Dasari on April 5, 2012. She had been seen on a monthly basis for medication refill. She had unresolved pain in the right low back and leg. Her right hip pain was more pronounced. She was able to lie on her right side for an hour only. She had been walking one block twice a day. She was diagnosed with failed back surgery syndrome and right lumbar radiculopathy. She was to continue taking Neurontin 300 mg, MS Contin 30 mg, Naprelan 500 mg daily, Amitiza 24 mcg daily, Baclofen 10 mg and she was prescribed an

LSO brace. PX.6.

Respondent filed a Petition for Rehabilitation Plan on April 27, 2012. The Respondent noted that Petitioner had permanent restrictions that Respondent could not accommodate. She underwent vocational rehabilitation for over a year. The Respondent was not satisfied with the efforts of its vendor and terminated the relationship. The Respondent hired Vocamotive as its new vocational counselor. The Respondent was confident that Vocamotive would be able to identify employment for Petitioner. RX.7.

Petitioner testified that she worked with Forte/Triune and there was nothing that made her believe working with a new company would help. T.68. She further testified that she declined the Respondent's offer of work-hardening and was not willing to go forward with work hardening. T.63.

Petitioner underwent an FCE on June 13, 2012 that was performed by Michael Hornbuckle of Flexeon Rehabilitation. Petitioner's attorney referred her to Flexeon. The test revealed that Ms. Perry gave a near full level of physical effort. The evaluator noted that Petitioner could do more physically at times than what she demonstrated. The FCE revealed that she should be limited to the sedentary physical demand level and handle up to 10 pounds occasionally for up to 2 hours with frequent rest breaks. She demonstrated the ability to stand, walk and sit for up to 2 hours at a time with frequent breaks of up to 5 minutes. She did not demonstrate the ability to be a competitive employee. She was unable to return to work on a full-time or part-time basis. She was a potentially difficult rehabilitation candidate due to her limited trunk and pelvic motion, and her poor ability to lift weights from the floor to knuckle height. She would perform best in an occupation that allowed frequent postural changes and little to no weight lifting for up to 2 hours a day. All placebo and special tests were negative. Petitioner noted that the next day her back hurt so bad that she had a hard time moving around and performing activities of daily living. PX.12.

Ms. Perry testified that she gets up around 8 to 9 o'clock in the morning. She only gets 2 hours of sleep at a time. She then stretches, has her coffee, takes a pain pill and a hot shower. T.35. The rest of the day she really does not do anything. Standing is the worse and causes her to lock up right away. She can walk for about 10 minutes. If she walks longer, then her sciatic nerve will kick in and the right side of her hip will start to lock up. T.36. She has a difficult time with the stairs in her house. Going up is better than going down. Prior to December 2005 she did not have any problems with physical activity. T.37. She used to enjoy mowing the grass and planting flowers. She also would ride her motorcycle with her husband. *Id.* If she rides her motorcycle for more than an hour now, she has to stop and walk around or else her back locks up. T.38. She currently notices that it is painful to sit, but if she keeps moving she can deal with it. T.44.

Dr. Harely Deutsch was deposed on April 20, 2012. He is board certified in neurological surgery. PX.13. He noted that the Petitioner exceeded his expectations in terms of recovery. Six months post surgery, her back pain went to 5 out of 10 and her right leg pain was 3 out of 10.

He saw her following the July 2010 FCE. The FCE indicated she was able to work at a

sedentary demand level. He agreed with the recommendation of lifting up to 10 pounds. PX.13. pg.15. He thought the restrictions were permanent. *Id.* He saw her on December 13, 2010 and noted Ms. Perry asked for restrictions that she could work 4 hours per day only. PX.13. pg.18.

He last saw Ms. Perry on February 17, 2012. Petitioner had resolution of most of her neck pain, but was complaining of lower back pain. He opined that her restrictions have remained the same. PX.13. pg.25.

On cross-examination, Dr. Deutsch noted that as of September 3, 2010, he was of the opinion that Petitioner could work a full 8 hour workday at a sedentary level. He did not restrict her from driving due to the medications. PX.13. pg.30. He noted that the Petitioner requested a 4 hour work restriction. He did not know if the 4 hour restriction was permanent, but it was reasonable given how long she had been off work. PX.13. pg.32. He opined that she was not permanently and totally disabled. *Id.*

Dr. Satish Dasari was deposed on April 24, 2012. He is board certified in anesthesiology. PX.14. pg.6. He noted that he saw the Petitioner every four to five weeks as opioids could not be refilled. PX.14. pg.42. He last saw the Petitioner on April 15, 2012. Petitioner's pain remained unchanged. She was taking Advil for increased right hip pain. She was taking Neurontin and her MS Contin and Morphine Sulfate remained the same. They took her off Advil and prescribed her Naprelan. They ordered a new back brace. PX.14. pg.50.

He stated that the Petitioner's pain levels from February 2011 through his last visit would be considered intractable pain. PX.14. pg.51. He stated that her current pain medication is opioid based and will remain in her system for an extended period of time. PX.14. pg.52. He noted that the Petitioner's condition is permanent. He stated that it was very unlikely Petitioner could return to work at the present time. *Id.* He stated that the diagnosis is failed back surgery syndrome.

On cross-examination, he testified that during the October 9, 2008 lumbar examination, her motor strength was difficult to evaluate due to her poor effort. PX.14. pg.57. He stated that with failed back syndrome, typically the spine looks good, their exam looks good but their pain is still present. So the dilemma is how to treat the person. PX.14. pg.59. He never reviewed the FCE. PX.14. pg.66. He agreed that Dr. Deutsch would be in the best position to make the determination as to her permanent restrictions. *Id.* From February 24, 2011 through the present, the Petitioner never indicated that her activities of daily living were diminished or decreased as a result of her prescription medication. PX.14. pg.68.

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois, Inc., Aero Mayflower Transit Co., Inc., v. Industrial Comm'n, 77 Ill. 2d 482, 487, 397 N.E.2d 804, 34 Ill. Dec. 132 (1979).* However, the employee need not be reduced to total physical incapacity before an award of PTD benefits may be granted. *Ceco Corp. v. Industrial Comm'n, 95 Ill. 2d 278, 286, 447 N.E.2d 842, 69 Ill. Dec. 407 (1983).* Rather, the employee must show that he is, for all practical purposes, unemployable, *i.e.*, he is unable to perform any services except those that are so limited in quantity, dependability, or quality that there is no reasonably stable market

for them. *Alano, 282 Ill. App. 3d at 534; Marathon Oil Co. v. Industrial Comm'n, 203 Ill. App. 3d 809, 815, 561 N.E.2d 141, 148 Ill. Dec. 835 (1990).* Therefore, if an employee can work without seriously endangering his health or life, he is not entitled to PTD benefits. *A.M.T.C. of Illinois, Inc., 77 Ill. 2d at 488.*

In this case, there is no medical evidence that the Petitioner was permanently and totally disabled. Rather, Dr. Deutsch testified that Petitioner was not permanently and totally disabled. Dr. Deutsch also noted that Petitioner exceeded his expectations in terms of recovery. The February 17, 2012 examination by Dr. Deutsch further supports that the Petitioner is not permanently and totally disabled. The examination of the cervical paraspinal muscles revealed no spasms and was normal in bulk. She had a negative Spurling test and a negative bilateral straight leg raise. The examination of the low back revealed no tenderness to palpation. The paraspinal muscles were normal in bulk and her range of motion included flexion up to 90 degrees and extension up to 20 degrees. Her legs demonstrated no tenderness to palpation. She had a solid fusion at L3 to S1.

Further, the FCE from July 6, 2010 revealed that Petitioner could perform at the sedentary level. The Commission finds the FCE of July 6, 2010 more credible than the June 13, 2012 FCE that was performed at the request of Petitioner's attorney. The June 2012 FCE concluded Petitioner was unable to return to work on a full-time or part-time basis. This finding is in direct conflict with the medical records. Dr. Deutsch was of the opinion that Petitioner could work with restrictions. Mr. Hornbuckle, who administered the FCE, acknowledged that Petitioner could do more physically than what she was demonstrating. Despite this admission, Mr. Hornbuckle still found that Petitioner was unable to work full or part-time. The Commission is not persuaded by this opinion. The Commission notes that the Petitioner refused to complete all the activities required during the July 6, 2010 FCE. The July 2010 FCE was not a full representation of Petitioner's abilities due to her self-limiting behavior; however, she was still found to be able to perform work at the sedentary level. It is the Commission's opinion that the Petitioner intentionally restricted her capabilities during the FCEs.

The Commission finds no objective evidence to support Petitioner's subjective complaints. There is no evidence that the Petitioner cannot work without endangering her health or life or that she is permanently and totally disabled.

If the employee's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, the burden is upon the employee to establish by a preponderance of the evidence that he falls into the "odd lot" category, that is, one who, though not altogether incapacitated to work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market. *Westin Hotel v. Workers' Compensation Comm'n*, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342, 310 Ill. Dec. 18 (2007). An employee satisfies his burden of proving that he falls into the odd-lot category by showing either (1) a diligent but unsuccessful attempt to find work or (2) that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. *Westin Hotel*, 372 Ill. App. 3d at 544. Once the employee establishes that he falls into the odd-lot category, the burden shifts to the employer to prove that some type of regular and continuous employment is available to the employee. *City of Chicago v. Workers'*

Compensation Comm'n, 373 Ill. App. 3d 1080, 1091, 871 N.E.2d 765, 313 Ill. Dec. 38 (2007); *Westin Hotel*, 372 Ill. App. 3d at 544; *Alano*, 282 Ill. App. 3d at 538. Whether the employee has met his burden of establishing that he falls into the odd-lot category and whether the employer has shown that some type of regular and consistent employment is available to the employee are questions of fact for the Commission. *E.R. Moore & Co. v. Industrial Comm'n*, 71 Ill. 2d 353, 361, 376 N.E.2d 206, 17 Ill. Dec. 207 (1978); *Alano*, 282 Ill. App. 3d at 538.

The Commission finds that the Petitioner failed to prove that she falls into the "odd lot" category of disability. She failed to prove a diligent but unsuccessful job search and she failed to prove that she is not able to be regularly employed in the labor market.

The Commission finds that the record is replete with instances where Petitioner intentionally restricted her ability to secure employment. The records revealed that Petitioner indicated to the vocational counselor that she had an inability to drive due to her medication. This is of interest as the Petitioner testified she is able to ride her motorcycle for an hour before her back locks up. She offered no testimony about her medication impairing her ability to ride her motorcycle in her leisure time; rather, her impairment is only when she needs to drive for employment. Dr. Dasari testified that Petitioner never indicated that her activities of daily living were diminished or decreased as a result of her prescription medication. The Commission finds Petitioner's statement about her driving not credible and is a deliberate attempt to sabotage her job search.

Additionally, the Petitioner was informed of a job fair where an employer would be interviewing on the spot. However, the Petitioner could not attend due to the stomach flu and because she had class that night. She alleged that this was "too much for her to juggle in a day." The Commission is not persuaded by this allegation and finds that it is another intentional act to restrict her ability to secure employment.

The record also establishes that she was using her disability as a barrier to employment. The evidence establishes that she voluntarily informed employers of her condition and restrictions, despite being advised to address those questions at a later date. In one instance, she received a call from one employer who told her about full-time work; however, Ms. Perry indicated she could only work part-time. One employer interviewed the Petitioner and noted that Ms. Perry voluntarily informed him of her back condition and her inability to drive due to morphine use. Another employer noted that Petitioner disclosed her back injury on her application.

There is also evidence that Petitioner was not willing to work second shift, the overnight shift and would not work Sundays. She argues that second or overnight shifts are difficult due to her back pain and she cannot work Sundays as this is the day she attends church. One employer noted that Petitioner indicated that she was able to work first shift only. The Commission is not persuaded by her allegation that her back condition prohibited her from working shifts other than first. The Petitioner offered no medical documentation indicating that she had to work first shift only. Also, her argument that she could not work Sundays due to church is incredulous. Church is not offered on Sundays only. She could attend church any other day of the week. Her job evaluation prior to her injury lends support that Petitioner was not willing to work shifts other

than first. The evaluation revealed that the employer wished she was more flexible in her work schedule especially working weekends. The Commission views her unwillingness to work other shifts or Sundays and her willingness to voluntarily disclose her restrictions as a deliberate attempt to sabotage her job search.

Furthermore, and as stated above, the FCEs revealed that Petitioner did not give a maximum effort. Despite this, she was placed at sedentary level. Ms. Perry then asked her doctor to limit her work to no more than 4 hours per day. She refused to undergo work hardening and refused to undergo a second vocational rehabilitation. The Petitioner is intentionally restricting her ability to secure employment.

The Commission finds the vocational opinions from Grzesik and Associates not persuasive. Mr. Grzesik was hired by Petitioner's attorney. Mr. Grzesik met with the Petitioner on one occasion only and held one telephone conference with her. Mr. Grzesik was of the opinion that Petitioner was unable to perform work activities of any occupation and met the criteria for odd-lot permanent total disability. Given Petitioner's credibility issues coupled with her self-limiting behavior, the Commission gives no weight to Mr. Grzesik's opinion.

The Commission modifies the Decision of the Arbitrator and finds Petitioner is not permanently and totally disabled. She is entitled to sixty-five percent loss of use of the person-as-a-whole for the injuries sustained on December 15, 2005.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 27, 2012, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $236.43 per week for a period of 69-5/7 weeks, commencing July 10, 2010 through November 11, 2011, that being the period of maintenance under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $213.00 per week for a period of 325 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the Petitioner sixty-five percent loss of use of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $11,225.82 for medical expenses under §8(a) of the Act, subject to the fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at

the sum of $12,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 2 8 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

MJB/tdm
O: 4-8-14
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0299

PERRY, GLENDA
Employee/Petitioner

Case# 06WC015927

SPEEDWAY SUPERAMERICA LLC
Employer/Respondent

On 12/27/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1658 SAUNDERS CONDON & KENNY
JAMES J KENNEY
111 W WASHINGTON ST SUITE 1001
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
GUY N MARAS
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

14IWCC0299

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Glenda Perry
Employee/Petitioner

v.

Speedway SuperAmerica, LLC
Employer/Respondent

Case # **06** WC **15927**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox, IL**, on **November 14, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

14IWCC0299

FINDINGS

On **December 15, 2005**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$18,460.00**; the average weekly wage was **$355.00**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **0** children under 18.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$84,699.05** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services of $11225.82, as provided in Section 8(a) of the Act, subject to the fee schedule. Respondent to receive credit for all sums previously paid hereunder.

Maintenance

Respondent shall pay Petitioner maintenance benefits of $236.43/week for 69-5/7 weeks, commencing July 10, 2010 through November 11, 2011, as provided in Section 8(a) of the Act.

Permanent Total Disability

Respondent shall pay Petitioner permanent and total disability benefits of $404.37/week for life, commencing **November 12, 2011**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

December 12, 2012
Date

DEC 27 2012

14IWCC0299

STATE OF ILLINOIS)
)
COUNTY OF WILL)

Nature and Extent TTD; MEDICAL;

GLENDA PERRY,)
)
Petitioner,)
)
vs.) I.C. #06 WC 15927
)
SPEEDWAY, LLC)
)
Respondent.)

MEMORANDUM OF DECISION OF ARBITRATOR

An Application for Adjustment of Claim was filed in this matter and notice of hearing mailed to each party. The matter was heard by an Arbitrator designated by the Commission in the City of Joliet, Illinois said County and State, on November 14, 2012. After hearing the proofs and allegations of the parties and having made careful inquiry in this matter the Arbitrator concludes:

A hearing in this matter was previously heard on June 21, 2006 pursuant to Section 19(b) of the Workers' Compensation Act. At that time, a hearing was necessitated due to a dispute whether Respondent was required to provide additional medical surgical and hospital services for injuries suffered by Petitioner that arose out of and in the course of her employment with Respondent. At this hearing it was stipulated that on December 12, 2005, the Respondent, SPEEDWAY, was operating under and subject to the provisions of the Illinois Workers' Compensation Act; and on this date the relationship of employee and employer existed between the Petitioner, Glenda Perry, and said Respondent; on the above mentioned date the Petitioner sustained accidental injuries which arose out of and in the course of the employment by the Respondent; timely notice of this accident was given the Respondent; the earnings of the Petitioner during the year next proceeding the injury were $18,510.77 and the average weekly wage was $355.00; Petitioner at the time of injury was 43 years of age, married and had no child under 18 years of age.

The issues in dispute at this hearing were:

(F) Is Petitioner's present condition of ill-being causally related to the injury?

(J) Were the medical services that were provided to the Petitioner reasonable and necessary?

(K) What amount of compensation is due for temporary total disability?

(O) Whether the surgery prescribed by Patrick Sweeney, M.D. is necessary to cure and treat Petitioner's condition of ill-being.

Petitioner, Glenda Perry was the sole witness to testify at trial. Medical records from Patrick Sweeney, MD, Jalil Piska, MD, St. James Occupational Health were introduced into evidence. Respondent presented no witnesses but did submit a medical report prepared by Dr. Orth following his Section 12 examination of Petitioner. On September 28, 2006, following the conclusion of this hearing, Arbitrator Dollison issued a decision, which states in pertinent part:

"In support of the Arbitrator's decision relating to disputed issues F, J, K and O, the Arbitrator finds the following facts:

On December 12, 2005 Petitioner sustained accidental injuries to her neck, left shoulder and low back due to an injury at work. In her employment, she ran a register, cleaned the store and refilled stock and products. The accident occurred when Ms. Perry was walking from an outside storage shed with an armful of cups and antifreeze. As she descended a ramp from the storage shed, Petitioner slipped on ice and fell backward, landing on her back. She felt an immediate onset of pain in her low back, neck and right shoulder.

The following day, Ms. Perry presented to St. James Occupational Health Clinic complaining of left shoulder, neck and low back pain. After x-rays were taken, Petitioner was released to return to work on a light duty basis. Respondent accommodated this restriction. Over the course of the next few days her symptoms worsened and radicular pain was reported. She returned to St. James Occupational Health and was prescribed a course of physical therapy. Therapy was not successful. On January 12, 2006, MRIs of the cervical and lumbar spine revealed the presence of a paracentral disc herniation at C5-6, bulging disc at C6-7 and a herniated disc at L5-S1 with mild encroachment and disc bulging at L4-5 with ligamentum flavum hypertrophy.

On January 26, 2006, Petitioner presented to Patrick Sweeney, M.D. complaining of severe neck and low back pain; radiating pain into right arm, parasthesias in the right arm. He prescribed epidural steroid injections to both the cervical and lumbar spine. Dr. Sweeney authorized the Petitioner off work. The injections, administered by Dr. Piska to Petitioner's cervical and lumbar spine provided no relief.

At Respondent's direction, Ms. Perry was evaluated by Dr. Orth on March 6, 2006 for an IME. Dr. Orth agreed with the diagnostic finding of the radiologist but disagreed that a causal relationship existed between the herniated discs and Petitioner's fall on December 15, 2005. Dr. Orth opined that Petitioner's complaints were due to degenerative disk disease in the cervical and lumbar spine and unrelated to the December, 2005 accident. Dr. Orth stated that Petitioner was at maximum medical improvement and could return to work without restrictions.

On April 10, 2006, Petitioner reported for work as directed by her employer. Ms. Perry began working the cash register. After working in a standing position for approximately one hour, Petitioner's low back and neck pain worsened and severe spasm developed in her cervical and lumbar spine. Petitioner left work and presented to the Emergency Room at St. James Medical Center. She received an injection which relieved her symptoms.

Ms. Perry returned to Dr. Sweeney who advised that surgery would be needed. To be sure, a myelogram was performed at St. James Medical Center which corroborated the herniated discs at C5-6 and at L4-5, L5-S1 with slight compression of the thecal sac and nerve roots. Ms. Perry experienced severe headaches as a sequellae of the myelogram. She presented to the emergency room at St. James and was provided with a blood patch. Petitioner then returned to Dr. Sweeney on May 11, 2006 for a review of the myelogram. Based upon these findings as well as prior diagnostic test results, Dr. Sweeney recommended that Ms. Perry first undergo an anterior cervical diskectomy with fusion at C5-6..."

Following the hearing, the Arbitrator found that the Petitioner sustained accidental injuries that arose out of and in the course of her employment on December 15, 2006 and that said injuries have resulted in severe injuries that require surgical intervention and which may, in the future require additional surgical care. As the Petitioner was released to return to work with significant sedentary restrictions which have increased her symptoms, the Arbitrator found that Petitioner was not able to return to work. As such Petitioner had demonstrated an entitlement to receive temporary total disability benefits from January 27, 2006 through the date of Arbitration. In addition, the Arbitrator agreed with the medical opinion of Dr. Sweeney that a causal connection exists between Petitioner's fall at work and her condition of ill-being in the cervical and lumbar spine. The Arbitrator found the prescription for surgical intervention at C5-6 to be reasonable and necessary and ordered that Respondent provide such care. Finally, the Arbitrator found that the emergency medical care received by Petitioner on March 1, 2006, April 10, 2006 and May 8, 2006 at St. James Medical Center; as well as the physical therapy charges from March 1 through March 31, 2006 and the myelogram performed at St. James to be reasonable and necessary.

Following the Award of the Arbitrator, Respondent chose to pay the award and agreed to provide further medical care.

Petitioner continued treatment with Dr. Sweeney. Dr. Sweeney prescribed a cervical fusion at C4-5, C5-6 as well as a fusion at L4-5, L5-S1. Due to the complexity of the lumbar fusion, Dr. Sweeney chose to perform the cervical fusion first. Because Ms. Perry smoked, Dr. Sweeney advised her to stop smoking prior to her surgery. Ms. Perry complied with this advice. The cervical fusion surgery was performed on November 26, 2006 at St. Margaret Hospital. Following this surgery, Ms. Perry noted a reduction in her neck pain and radicular symptoms. Postoperatively, Dr. Sweeney prescribed Norco, vicodin and flexeril to control Petitioner's pain. Petitioner returned to Dr. Sweeney periodically so that he could monitor the progress of the fusion. Petitioner refrained from smoking and Dr. Sweeney noted that the fusion was healing.

While Petitioner noted an improvement in her cervical complaints, she continued to experience severe low back pain. When Dr. Sweeney examined her on December 12, 2006, he administered a trigger point injection in the PSIS junction. A second injection was administered to this region in April, 2007. Overall Sweeney was satisfied with the union of the cervical fusion.

Dr. Sweeney had obtained authorization from the carrier to perform a discogram. This study, performed in April, 2007, was provocative at L4-5 and L5-S1 and confirmed the need for surgery. The carrier authorized the lumbar surgery which was scheduled for May 14, 2007. As before, Dr. Sweeney advised Ms. Perry to stop smoking prior to the lumbar surgery. Again Ms. Perry complied and stopped smoking prior to the surgery. Dr. Sweeney performed the lumbar fusion with instrumentation on 2007 at St. Margaret Hospital. Postoperatively, Petitioner returned to Dr. Sweeney so that he could assess the healing of the fusion. When she returned to Sweeney's office 10 days after the lumbar fusion, Petitioner was complaining of spasm in the low back and pain radiating into the right posterior thigh into the calf. Dr. Sweeney prescribed Norco and Neurontin. He reported that Ms. Perry had reached maximum medical improvement with regard to the cervical spine. The neurontin helped control Petitioner's radicular complaints. Dr. Sweeney reported that x-rays demonstrated good alignment of the lumbar fusion.

In June, 2007, Dr. Sweeney prescribed a course of physical therapy. This therapy, performed at Minimally Invasive Spine Rehab Center over a three month period, consisted of exercise and stretching. It was reported that Petitioner could tolerate walking on a treadmill for 13 minutes and could tolerate sitting for 1 ½ hours. Petitioner continued to complain of experiencing muscle spasm radiating down her right leg several times per day with an increase in her low back pain. In July, Petitioner reported to Dr. Sweeney that she was taking 4 vicodin per day as well as the Norco. Although she was able to lie in bed all night, she was only able to sleep 1 ½ to 2 hours per night. In August, Petitioner complained of increased low back pain when lifting heavier weights at therapy. She had resumed smoking and Dr. Sweeney advised her to stop. Petitioner followed this advice. He also suspended physical therapy until he was sure the fusion was healing. On October 18, 2007, Petitioner advised Dr. Sweeney she had stabbing pain in her back while descending stairs. X-rays showed the screws were in good position. Petitioner was advised t wear her lumbar brace. When she returned in November, Petitioner reported her low back pain had improved. X-rays demonstrated loosening of the L4 pedicle screw. Dr. Sweeney prescribed a bone stimulator to promote bone formation in the fusion. Petitioner was having difficulty stopping smoking for any extended period. She advised Dr. Sweeney she had an appointment with her family doctor to obtain a prescription for Chantix.

On December 24, 2007, Petitioner advised Dr. Sweeney she was using the stimulator four hours per day as instructed. Petitioner obtained the prescription for Chantix but developed severe chest pains which caused her to go to the Emergency Room at St. Margaret Hospital on December 5, 2007. X-rays demonstrated that the fusion had failed. When Ms. Perry returned in January there was no change in the x-rays.

Respondent directed Petitioner to be examined by Andrew Zelby, MD on January 28, 2008, for a Section 12 examination. Following this examination, Dr.Zelby opined that Petitioner's low back condition was due to a degenerative disc condition in the lumbar spine and

not related to the work accident of December 15, 2005. A similar opinion, stated by Dr. Orth in March 2006, was expressly rejected by the arbitrator in his September 28, 2006 award. Arbitrator Dollison ruled that Petitioner established that the accident of December 15, 2005 caused Petitioner to suffer herniated discs at C5-6, L4-5 and L5-S1 Zelby stated a fusion was not an appropriate procedure to treat degenerative disk disease. He agreed the fusion in the cervical spine was appropriate and that Petitioner had reached maximum medical improvement. She was capable to return to work with a 30 pound restriction.

Dr. Zelby further stated in his January, 2008 report and its addendum dated April 7, 2008, that the lumbar fusion did not heal and that pseudoarthrosis occurred. While Petitioner required a second fusion, surgery was inappropriate due to Petitioner's inability to stop smoking and that only smoking cessation and the use of a bone stimulator would achieve a solid arthrodesis in the lumbar spine.

Based upon the report of Dr. Zelby, Respondent refused to authorize any further surgery unless Petitioner stopped smoking. Petitioner was in severe pain and the pseudoarthrosis and spinal instability was the source of such pain. Because Dr. Sweeney was not provided with authorization to perform the necessary surgery to relieve Petitioner's symptoms, he referred Petitioner to Dr. Dasari, a pain specialist who could provide palliative care. Dr. Dasari began to provide treatment to Petitioner in 2008.

Petitioner sought an orthopedic consultation with Harel Deutsch, MD. Dr. Deutsch examined Ms. Perry on April 5, 2008 and agreed with Dr. Sweeney that Petitioner required surgery. He proposed using a morphogenic protein during surgery which would stimulate bone growth. According to Dr. Deutsch, use of this protein would give a smoker the same level of success as a non-smoker. Still Respondent refused to authorize surgery. Petitioner filed an emergency Petition for medical care pursuant to Section 8(a) of the Act.

Petitioner participated in numerous programs to help her stop smoking. She had been smoking for more than thirty years. Over the course of the next year, Petitioner participated in various programs to help her stop smoking. She had laser treatment, hypnosis, accupuncture as well as programs promoted by Respondent to help her stop smoking. On October 17, 2008, Petitioner was evaluated by Jody Reed, a psychologist. In this examination, Dr. Reed reported that Petitioner was suffering from major depression, dysthemic disorder and a chronic pain syndrome. It was hoped Petitioner would benefit from psychotherapy to help her stop smoking On February 25. 2009, Respondent directed Ms. Perry to Dr, Galetzer-Levy for a psychological evaluation. Dr. Galetzer-Levy found that Petitioner was suffering from severe depression which was caused in part by her work accident. He reported that she was motivated to return to work and that he found no indication of secondary gain or malingering behaviors. Petitioner had also participated in a smoking cessation program sponsored by the University of Chicago.

Petitioner remained under the care of Dr. Dasari and Dr. Deutsch. Deutsch, like Sweeney before him, was not given authorization to perform surgery. Because Petitioner suffered from a mechanical failure in her lumbar spine, Dr. Deutsch only had a surgical option to treat this

condition. Dr. Dasari continued with his palliative care, attempting to provide pain relief until a surgical option could be achieved. Dasari reported that Petitioner's pain level was consistently 8-9/10 and she reported occasional bladder control issues. She was having difficulty thinking. Dasari had been prescribing Lidoderm patches, Opana, Neurontin and Amitiza. He also advised that Petitioner use her LSO brace.

During this time Petitioner's physical and psychological condition continued to deteriorate. Her case proceeded to trial in April, 2009. As in the earlier hearing, Ms. Perry was the only witness to testify. Petitioner testified as to the intractable low back pain she experienced, muscle spasm and bilateral leg radicular symptoms. She acknowledged her struggles trying to stop smoking. She had success prior to her cervical fusion when she utilized nicotine patches and substitutes. The emotional stress caused by her relentless physical pain and inability to obtain pain relief was compounded by the demand that she stop smoking. Following this testimony, this matter was continued to May, 2009 to close proofs and submit medical records and reports. The case was further continued. In June, 2009, the Illinois Appellate Court, Workers' Compensation Division rendered a decision in the case of *Global Products v. Illinois Workers Compensation Commission*, (2009) 329 Ill.App3d 408; 911 N.E.2d 1042; 331 Ill.Dec. 812 In this case, the Court ruled that an employer could not reasonably deny a repeat fusion surgery to an injured worker on the basis that the worker smoked. Following the publication of this decision, Respondent authorized the repeat lumbar fusion. Proofs were never closed in this matter - no medical records or reports were submitted into evidence and the Arbitrator never rendered a decision.

Dr. Deutsch performed the repeat lumbar fusion on September 29, 2009 at Rush. He removed the hardware which had loosened. He utilized the morphogenic protein and replaced the instrumentation. The fusion site extended from L3 to S1. Upon her discharge from Rush Hospital, Dr. Deutsch prescribed neurontin, opana, amitiza, xanax, celexa, protonics, flector and Lidoderm patch. Following surgery, Ms. Perry noticed the radicular pain in her legs had improved although her back pain persisted. Ms. Perry returned to Dr. Deutsch for post-operative visits. Dr. Deutsch ordered x-rays to be performed to monitor the progress of the bone healing at the fusion site. Satisfied with the progress of her bone growth and the stability of the lumbar spine, Dr. Deutsch prescribed physical therapy.

Petitioner participated in physical therapy and reported further improvement. Deutsch continued the pain medications and prescribed aqua therapy. This treatment, which was performed in a pool helped support Petitioner's weight, reducing stress on her back and lower extremities. In July, 2010, Petitioner underwent a CT scan at Rush University which mild levoscoliosis at L4-5; L4-5 hemilaminectomy defect at location of screw removal, L5-S1 hemilaminectomy and a left lateral disc herniation at L3-4. Dr. Deutsch prescribed that Petitioner participate in an FCE. This study was performed at St. Mary Medical Center on July 6, 2010. The charge for this study, $1,001.00, was never paid by Respondent. Petitioner was experiencing difficulty with the lifting aspects of the test. When she started the test, her pain level was 4/10. Thereafter it increased to 10/10. This study demonstrated that Petitioner was capable of working only at a sedentary level. Based upon the results of the FCE, Dr. Deutsch discharged her from

care and placed permanent restrictions of no lifting in excess of 10 pounds. He stated Petitioner was at maximum medical improvement and would not benefit from further care. He did however continue the Petitioner's pain medications.

Based upon this statement, Respondent refused to provide any further medical care, including prescriptions. Petitioner returned to Dr. Deutsch in September, 2010. Dr. Deutsch clarified his statement regarding Petitioner's need for further medical care. While Petitioner would not benefit from further surgery or therapy, she does continue to require continued medications. He prescribed Norco and Robaxin. Ms. Perry was to return to him in 3 - 6 months.

As Petitioner had been terminated by Respondent in 2006, there was no sedentary work available with Respondent. Following her release to return to work in a sedentary capacity, Petitioner began her own job search, contacting various prospective employers near her home in Crete, Illinois. Petitioner submitted applications for employment to more than fifty prospective employers. She was not successful in obtaining employment. A copy of the job search records was submitted into evidence.

In October, 2010, Respondent sought to provide vocational rehabilitation services to Petitioner. Petitioner was a 50 year old woman with a GED. After high school, she had no other formal education. In her adult life she worked in a number of unskilled labor jobs. At Speedway, Petitioner had been a clerk/associate for several years. She did not have any office skills or experience, she had no typing skills, no computer skills. Respondent assigned Triune to administer the vocational rehabilitation of Ms. Perry. Monika Dabrowiecka, MA was the vocational person assigned to assist Ms. Perry. From November 2010 to January, 2012, Petitioner submitted more than 500 applications for employment. Petitioner went on several job interviews without success. In addition, Petitioner participated in basic computer skills classes as well as typing classes to improve her chances at becoming employed. Petitioner met with Ms. Dabrowiecka on a weekly basis at the Crete Public Library to review job leads and employment opportunities and review the submissions made by Petitioner. In January, Respondent terminated the vocational efforts of Triune. Respondent did not utilize the services of a Certified Rehabilitation Specialist with regard to the vocational plan implemented by Respondent.

Petitioner returned to Dr. Deutsch on December 2010. While she had enjoyed some improvement following the repeat fusion, she was still having significant difficulties with her day to day activities. Ms. Perry was capable of sitting or standing for no more than an hour at a time. She was unable to sleep for more than 2 - 3 hours at a time. She continued to take the medication prescribed by Dr. Deutsch and employed home remedies such as taking hot showers several times a day. These measures only provided temporary relief. Based on these complaints, she advised Dr. Deutsch she could only perform work type activities for 4 hours at a time. Dr. Deutsch prescribed a repeat CT scan, Flexeril and advised Ms. Perry to return to see him in January, 2011.

Ms. Perry returned on January 31, 2011 at which time he reviewed the results of the CT scan with Petitioner. This study indicated mild degenerative changes at L2-3; mild disc bulge at L3-4;

Residual canal narrowing at L4-5 due to diffuse disc bulge and thickening of the ligamentum flavum and impingement on the thecal sac posteriorlaterally at L5-S1. Petitioner reported having trouble with prolonged sitting or standing more than 2 hours. He restricted her activities to 4 hours. He also advised Petitioner to return to Dr. Dasari to treat her chronic pain condition.

Petitioner returned to Dr. Dasari on February 24, 2011. She reported that she had the repeat fusion. At the time of this visit she reported pain levels of 4-7/10. She was having trouble thinking. Dr. Dasari prescribed a duragesic patch, and Robaxin. Petitioner returned to Dr. Dasari two weeks later stating she had an allergic to the duragesic patch. She was then prescribed Embeda and she tolerated this medication. When she returned two weeks later, MScontin was also prescribed. Dr. Dasari provided a topical analgesic for Petitioner to apply to her back. MScontin was an opioid. Despite the medications prescribed by Dr. Dasari, Petitioner was never pain free. The MScontin controlled her back pain and the muscle spasms in her legs were controlled by Robaxin or Amitiza. Petitioner continued to see Dr. Dasari on a monthly basis through the date of hearing. At the time of hearing, Petitioner was taking the following medications: MScontin, Flexeril; Baclofen, Amitiza and advised that Ms. Perry continue with her LSO brace. Dr. Dasari would prescribe periodic blood tests to measure the medication levels in Petitioncr's system.

In July 2011, Petitioner was evaluated by Thomas Grzesik, a Certified Rehabilitation Counselor who maintained an office in Schererville, IN. Mr. Grzesik interviewed Ms. Perry at her home. Mr. Grzesik reviewed Petitioner's medical records, her vocational records from Triune, reviewed her medications and conducted a face to face interview with Petitioner. It was Mr. Grzesik's opinion that Ms. Perry was not employable based upon her limited education, her limited work experience, her lack of transferrable skills, her personal/physical limitations and her use of opiate based medications which prevented her from operating a motor vehicle when such medications were in her system.

In June, 2012, Petitioner participated in another functional capacity evaluation with Flexeon Physical Therapy. This test which lasted several hours required Ms. Perry to perform a number of simulated work-like activities. The examiner found that Ms. Perry provided good effort. Ms. Perry was found to be unable to perform any work activities more than two hours per day.

In July, 2012, Thomas Grzesik had an opportunity to review the depositions of Dr. Deutsch and Dr. Dasari. He also had the opportunity to review the Functional Capacity Evaluation performed at Flexeon.

This matter proceeded to trial on November 14, 2012. At this hearing it was stipulated that on December 12, 2005, the Respondent, SPEEDWAY, was operating under and subject to the provisions of the Illinois Workers' Compensation Act; and on this date the relationship of employee and employer existed between the Petitioner, Glenda Perry, and said Respondent; on the above mentioned date the Petitioner sustained accidental injuries which arose out of and in the course of the employment by the Respondent; timely notice of this accident was given the

Respondent; the earnings of the Petitioner during the year next proceeding the injury were $18,510.77 and the average weekly wage was $355.00; Petitioner at the time of injury was 43 years of age, married and had no child under 18 years of age. It was further stipulated that Petitioner had been temporarily totally disabled from December 29, 2005 to November 14, 2012 and that the sum of $84,699.05 had been paid in temporary total disability benefits.

The issues in dispute were:

(F) Is Petitioner's present condition of ill-being causally related to the injury?

(J) Were the medical services that were provided to the Petitioner reasonable and necessary?

(N) Nature and extent of Petitioner's claimed injury

(O) Whether Respondent may be permitted to pursue further vocational rehabilitation.

As before, Ms. Perry testified at hearing. In addition, Dr. Deutsch and Dr. Dasari testified pursuant to Respondent's Dedimus Postestatum. Dr. Deutsch'e evidence deposition was taken on April 20, 2012 and Dr. Dasari's evidence deposition was taken on April 24, 2012. At trial Petitioner submitted the medical records of Dr. Sweeney, St. Margaret Hospital, Dr. Deutsch, Dr. Dasari, Dr. Reed, Dr. Galetzer-Levy, Mary Lee, RN, PsyD, Forte/Triune (vocational rehabilitation) and reports of Flexeon Physical Therapy (June 2012 FCE) and reports of Thomas Grzesik, MS, MA, CRS, LCPC. Respondent presented no witnesses at hearing. Respondent submitted records from St. Mary Hospital (FCE); Forte/Triune; Reports from Dr. Zelby (1-28-08; 4-07-08); Dr. Orth (1-13-06); Dr. Galetzer-Levy(3-4-09) ; Utilization Review (01-20-09)

At Hearing, Petitioner testified that although the repeat fusion greatly reduced her lower extremity pain, she was never pain free. The back pain was always present. She was taking morphine to control her day to day low back pain and provide her with some level of comfort. She continued to experience spasm in her legs several times per day which she controlled taking baclofen or robaxin. She described an inability to sleep through the night. When she rises in the morning, it takes 15-20 minutes each morning stretching her body so that she could get to her feet. Petitioner described her inability to sit for more than two hours at a time and her inability to stand for any extended length. She often feels fatigued taking her medication but it does provide enough pain relief to allow her to make through the day. She testified that in July, 2010, Avizent, the workers' compensation carrier for Respondent refused to pay any medical expenses for treatment she received from Dr. Deutsch, Dr. Dasari, prescription expenses, lab work. It was necessary for her husband's union Health & Welfare Fund to pay for medical care, prescription expenses and lab work. Petitioner submitted billing statements from the following medical providers; EMPI $1,523.05; LabCorp $387.00; Rush University Med. Group $177.00; Lake Imaging $ 85.00; Informed Mail $270.00; Millenium Labs $ 36.96; Pain Management Specialists $267.74; Midwest Interventional Spine $618.40; Dr. Zavala $230.00; DiaTri $ 345.00; Subrogation Local 731 $6,698.80. In addition Petitioner paid the following out of pocket costs:

cane $23.09; Laser $270.00; St. Margaret $293.85;

In his evidence deposition, Dr. Deutsch testified that the lumbar fusion surgery he performed was causally related to Petitioner's work injury of December 2005. Dr. Deutsch described his use of the morphogenic protein during the second lumbar surgery. This protein enhanced bone growth at the fusion site which ultimately healed to a solid fusion. Dr. Deutsch further clarified that although Petitioner had reached maximum medical improvement in July, 2010, he did opine that Petitioner required further pain medication and other palliative care to make her pain levels tolerable. While he acknowledged that Petitioner could likely perform some type of work based upon her physical limitations, he acknowledged that he possessed no expertise in vocational rehabilitation. He admitted that Petitioner's use of presciption opiate medications would interfere in her ability to operate a motor vehicle. While he was satisfied that Petitioner was limited to working four hours per day, he stated it was possible that a work hardening program could improve her stamina. He could not offer any particular protocol and would defer to a therapist. He never changed Petitioner's restrictions. From a pain management standpoint, he would defer to Dr. Dasari who was Petitioner's treating physician.

Dr. Dasari was more blunt in his testimony. Petitioner's resulting physical condition which developed as a result of her work injury required the use of morphine and other heavy duty medications to control her pain. Based upon Petitioner's pain level and the use of the opiates described, he felt that it was very unlikely that Petitioner would be able to work.. According to Dr. Dasari, Petitioner would always require pain medication to control her pain.

In support of the Arbitrator's decision relating to disputed issues F, J, K and O, the Arbitrator finds the following facts:

On December 12, 2005 Petitioner sustained accidental injuries to her neck, left shoulder and low back due to an injury at work. This accident caused Petitioner to sustain a herniated disc at C5-6; and herniated discs at L4-5 and L5-S1 which arose out of and in the course of her employment with Respondent. Petitioner underwent a cervical fusion at C5-6 which was reasonable and necessary to cure her condition of ill-being in her cervical spine. Respondent has paid all reasonable and necessary medical expenses pertaining to Petitioner's cervical spine fusion. Petitioner reached maximum medical improvement in the cervical spine in May 2007.

With regard to treatment Petitioner received to her lumbar spine, Petitioner underwent a lumbar fusion at L4-5 to L5-S1 which was reasonable and necessary to treat her condition of ill-being in her lumbar spine. The lumbar fusion surgery performed by Dr. Sweeney on May 14, 2007 was appropriate to treat the herniated discs at L4-5 and L5-S1. The arbitrator finds that the fusion did not heal. Although Petitioner was a smoker, she was a smoker long before she had been employed by Respondent. The Arbitrator finds that he is bound to reject the argument that Petitioner engaged in an injurious practice and adheres to the rationale of the appellate court in *Global Products v. Illinois Workers Compensation Commission.* 329 Ill.App3d 408; 911 N.E.2d 1042; 331 Ill.Dec. 812 Despite Petitioner's inability to stop smoking, Petitioner demonstrated a willingness to follow medical advice. She continued to attempt to stop her smoking. The Arbitrator further notes that the repeat lumbar fusion was also reasonable and necessary to treat

Petitioner's condition of ill-being. Dr. Deutsch, performed the second fusion using a morphogenic protein. This protein enhanced bone growth and created a solid fusion from L3-S1.

The testimony of Dr. Deutsch credibly established that Petitioner suffered from severe permanent restrictions in her lumbar spine following two fusion procedures. The restriction place by Dr. Deutsch were consistent with Petitioner's resulting physical condition, her continuing physical complaints, her description of her physical capabilities and the results of the July 2010 FCE and later study performed in 2012. The arbitrator also finds the testimony of Dr. Dasari compelling. The Arbitrator finds that the level of pain medication required by Petitioner was reasonable and necessary to control her pain and that such opiate based medications prevent Petitioner from safely operating a motor vehicle under Illinois law.

Petitioner testified credibly before the Arbitrator. As the medical evidence proved that Petitioner was capable to return to work only in a sedentary capacity, her self-directed efforts to find work were appropriate and taken in good faith. Thereafter, when Respondent provided vocational rehabilitation services, the Arbitrator finds the Petitioner cooperated fully with such efforts, submitting more than 500 applications/jobsearches.

The Arbitrator finds that the medical bills submitted by Petitioner were causally related to Petitioner's injury, It was improper for Respondent to refuse to pay such medical expenses based upon Dr. Deutsch's statement that Petitioner had reached maximum medical improvement. Both Dr. Deutsch and Dr. Dasari testified as to Petitioner's need for palliative medical care and Respondent provided no medical evidence that such care was either unnecessary or not causally related to the work accident. As such the Arbitrator awards the following medical bills: EMPI $1,523.05; LabCorp $387.00; Rush University Med. Group $177.00; Lake Imaging $ 85.00; Informed Mail $270.00; Millenium Labs $ 36.96; Pain Management Specialists $267.74; Midwest Interventional Spine $618.40; Dr. Zavala $230.00; DiaTri $ 345.00; Subrogation Local 731 $6,698.80. In addition Petitioner paid the following out of pocket costs: cane $23.09; Laser $270.00; St. Margaret $293.85;.

Finally, the Arbitrator concludes that based upon the totality of the evidence that Petitioner has demonstrated that she is permanently and totally disabled. Medical records indicate that Petitioner's condition had reached maximum medical improvement on July 10, 2010. She thereafter commenced a self directed job search and then in November of 2010 began formal vocational rehabilitation as directed by Respondent. This lasted until November 11, 2011 at which time Respondent apparently terminated vocational rehabilitation efforts after Petitoner had made more than 500 job contacts and not obtained a single interview.. In March of 2012 Respondent offered to restart voc rehab but this was apparently declined by Petitioner. Based on the record as a whole, the Arbitrator finds that Petitioner is awarded maintenance benefits from July 10, 2010 through November 11, 2011, in the amount of $236.43 per week and that thereafter the Petitioner is entitled to receive permanent total disability benefits in the amount of $404.37 per week that have accrued since said date and continuing.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Ghezzi,

Petitioner,

vs.

NO: 12 WC 31556

14IWCC0300

Spectrum Contracting,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, temporary total disability, medical expenses, prospective medical expenses, benefit rates and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 10, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

14IWCC0300

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: APR 2 8 2014

MB/mam
O:4/17/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR
& (A)

GHEZZI, DAVID
Employee/Petitioner

Case# **12WC031556**

14IWCC0300

SPECTRUM CONTRACTING
Employer/Respondent

On 7/10/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2675 COVEN LAW GROUP
LARRY J COVEN
180 N LASALLE ST SUITE 3650
CHICAGO, IL 60601

0532 HOLECEK & ASSOCIATES
LINDSAY REINER
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

14IWCC0300

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
19(B) & 8(A) DECISION

David Ghezzi
Employee/Petitioner

v.

Spectrum Contracting
Employer/Respondent

Case # 12 WC 31556

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **04-30-13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [ ] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **prospective medical**

FINDINGS

On **07-21-12**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $ **32,942.00**; the average weekly wage was $ **633.50**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **2** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary disability benefits of $ 422.33 /week for 23.286 weeks, commencing 11-19-12 through 04-30-13, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $ 4,534.00.

Prospective medical care is awarded in the form of cortisone injections prescribed by Dr. Domb.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

07-10-13
Date

JUL 10 2013

FINDINGS OF FACT

Testimony of David Ghezzi:

Petitioner testified that he is a 58 year old male that has made a career as a laborer, mason, and real estate developer. Petitioner testified that up until the economic down turn a few years ago, he was a principal at Ghezzi Masonry, LLC, a unionized residential masonry company. Petitioner testified that this was a large successful masonry company that was started in the 1950's by his dad. Petitioner testified that as a result of the economic downturn, new work dried up as builders went out of business. Petitioner testified that to make a living, he started to use his laborer's card to get work from a couple of different Unions as well as any other side work including home remodels. Petitioner testified that prior to 7/21/12 he was in great physical shape. Petitioner testified that he would regularly take 15-30 mile bicycle rides as well as jog on average 20 miles / week. Petitioner testified that he was struck by a car when he was four years old injuring his right hip which resulted in a permanent limp. However, Petitioner testified that he had no pain, no treatment, and no disability from the hip for over 50 years. Petitioner testified that on July 21, 2012, prior to going to work, he took a 15 mile bicycle ride with his friend Wayne Borg. Petitioner testified that he has not gone for any bicycle rides or runs since he was injured on 7/21/12 while working on the Metra line for Respondent.

Petitioner testified that on July 20, 2012 he received a call from Mark LaPore, a Union Representative. Mr. LaPore offered Petitioner a 2 day job working on concrete repair and membrane installation on a bridge located on the Metra line in Chicago. The job was to start on 7/21/12 at 5:00 P.M. and work through the night into Sunday until all work was completed. Salary for the job was $36.20 / hour base, $54.30 / hour for Saturday at time and a half, and $72.40 / hour for Sunday at double time. The job required them to be done and off the tracks

before rush hour on Monday, 7/23/12. Mr. LaPore supplied Petitioner with the cellular numbers of the two supervisors on the job, Rob Stelter and Kurt Wessel. Mr. LaPore asked Petitioner to give a ride to the jobsite to another worker, Tom McDermott. Petitioner was not friends with Tom McDermott and had only met him on one prior occasion when he gave him a ride to a different job site. (Transcript P. 13). On the afternoon of July 21, 2012 Petitioner picked up Tom McDermott at his home in Orland Park to travel to the jobsite.

Petitioner arrived at the jobsite, parked, and contacted Kirk Wessel, a supervisor for Respondent. Petitioner and Tom McDermott met up with Kirk Wessel and the other supervisor, Rob Stelter. Petitioner was immediately directed to move his car to a different location. Tom McDermott stayed at the jobsite. When Petitioner returned to the jobsite, he was given a bright yellow safety vest and gloves. Petitioner did not sign any safety training forms and did not attend any safety training. No other safety gear was issued to Petitioner.

Petitioner and Tom McDermott testified that they worked together during the entire job. Petitioner testified there first task was to grind down concrete. After doing that for a few hours they were given primer to apply to all the concrete. The concrete was being primed so that a membrane could be installed. The process included using power sprayers in which Petitioner would be down on his hands and knees holding the membrane in place while chemical primer was being sprayed over his shoulder causing chemical to splash onto the back of his neck. Petitioner and Tom McDermott testified that after working with the primer for about an hour they started to burn on the back of their necks. Both Petitioner and Tom McDermott testified that this was not a sun burn as it was dark out the majority of the time they worked with the primer. Petitioner and Tom McDermott testified that they approached the supervisors on three separate occasions to complain about the burns. Petitioner and Tom McDermott testified that

they were not sure which supervisor was Kirk Wessel and which was Rob Stelter, but they knew they were the supervisors. On each occasion they were told that the primer does not have anything in it that would cause a burn. Petitioner testified that about 3:00-4:00 in the morning he went searching for a rag to put water on so he would wipe down the back of his neck. Petitioner testified that he felt like his neck was on fire. Petitioner testified that he walked about 30-40 feet away from Tom McDermott on a bridge in search of a rag. As Petitioner walked there was a plank covering a hole in the ground. Petitioner testified that he tripped on the plank landing on his right side striking his hip, lower back and head. As a result of the fall, Petitioner began to bleed from his nose and a cut on his head. Petitioner testified that he used his work issued safety vest to wipe the blood. The Respondent issued vest with all the dried blood was presented and viewed by all parties at the hearing. The vest was identified as the one that was provided at the jobsite and appeared to be stained with significant amounts of dried blood. Petitioner testified that after a few seconds he stood up and walked past Tom McDermott who inquired if he was OK and then over to one of the two supervisors. Petitioner testified that he advised the supervisor that he had fallen and asked if they had anything to help stop the bleeding. At this point Petitioner was using his safety vest. Petitioner testified that he was offered no assistance. Petitioner then walked back past Tom McDermott in search of something other than vest to control the bleeding. Petitioner testified that he found a rag, got the bleeding under control, and returned to work. Petitioner and Tom McDermott testified that the burning on their necks continued to get worse.

About 7:00 A.M. Petitioner and Tom McDermott again complained to the supervisor about their necks burning. Tom McDermott testified that during this conversation Petitioner also complained that his hip still hurt from his fall on the jobsite. Tom McDermott said he could not

handle the burning anymore and left the jobsite to sit in Petitioner's car. Tom McDermott did not return to the job site. About 10:00 Petitioner testified that he could no longer take the burning or the hip / back pain and he advised the supervisors that he was leaving. Petitioner returned to his car and Tom McDermott drove home because Petitioner was in too much pain.

After dropping Tom McDermott off, the Petitioner called his primary care physician, John Oliveri, M.D. on his cell phone. As of July 22, 2012, at all times while treating the Petitioner, Dr. Oliveri was a board certified licensed internal medicine medical doctor in the State of Illinois. Dr. Oliveri regularly gave his cell phone number to his patients to call when the need arose. Dr. Oliveri advised Petitioner to meet him at the office that afternoon. On the afternoon of July 22, 2012 Dr. Oliveri's records clearly lay out the fact that Petitioner had an accident at the Metra Station while working sustaining an injury to his right hip and back as well as chemical burn. Dr. Oliveri's records along with his evidence deposition were admitted into evidence. Dr. Oliveri examined Petitioner, diagnosed the chemical burn and the hip / back pain. Dr. Oliveri testified that based on the fact that they were working at night and the fresh blistering and oozing appearance of the burn, he concluded that it was a fresh chemical burn sustained while working Dr. Oliveri gave Petitioner cream for the burn and offered prescription pain meds which Petitioner turned down instead opting to use Advil for pain. Petitioner testified that he turned down the pain medication at this point as he tries to avoid narcotics because he has hepatitis. As directed, Petitioner returned to Dr. Oliveri on 7/25/12 reporting that the chemical burn was improving but the hip / back pain was not. Petitioner deferred a pain prescription but accepted samples of Celebrex for pain. Petitioner reported that the burn was improving but the hip and lower back were still very painful. Dr. Oliveri gave Petitioner more cream for the burn and gave him Celebrex samples for the pain. On August 21, 2012 the Petitioner was hired by the

Union to work at the BP Amoco Plant where he was given the job of fire watcher. Petitioner's job was to sit on a stool and watch for fires. Petitioner did no physical labor on this job. Petitioner testified that this job lasted about 2 months. Petitioner testified being unable to get a workers' compensation claim set up and not having enough hours into get group insurance through the Union, he attempted to deal with the pain. At trial we heard tape recorded phone calls the Petitioner had in August 2012 with each supervisor again requesting workers compensation assistance. No assistance was offered or given. Petitioner returned to see Dr. Oliveri on September 25, 2012. Petitioner reported that the pain in the hip and back was not improving. Dr. Oliveri gave Petitioner steroid and xylocaine injection in the right hip, took more X-Rays, and directed him to follow-up in a week. Petitioner testified he was now taking vicodin provided by Dr. Oliveri for the pain. Petitioner testified that the pain was not improving and Dr. Oliveri recommended that Petitioner follow-up with an orthopedic. Dr. Oliveri referred Petitioner to Hinsdale Orthopedics. With a workers' compensation claim finally opened by Respondent, an agreement was eventually worked out with workers' compensation that allowed Petitioner to get an orthopedic consultation at Hinsdale Orthopedics. On November 19, 2012 Petitioner was seen by Benjamin Domb, M.D. at Hinsdale Orthopedics. Dr. Domb is a board certified orthopedic surgeon specializing in hip injuries. Petitioner gave the same history to Dr. Domb of a chemical burn and injury to the hip back, and head while working in July. Dr. Domb's assessment was a right hip injury in July and lumbar spinal radiculopathy. Dr. Domb further stated that there was a clinical indication of a possible labral tear vs. arthritis vs. other intra articular derangement. Dr. Domb took the Petitioner off of work, administered an intra-capsular injection into the right hip, ordered a lumbar MRI, referred Petitioner to Dr. Lorenz or Dr. Zindrick for a spinal consultation, and directed him to return in 6 weeks. The lumbar MRI

was completed on November 23, 2013. Petitioner attempted to schedule a follow-up with Dr. Domb but Respondent would not approve a return visit. Petitioner testified that the right hip injection helped for 2-3 weeks before wearing off, which confirms the diagnosis of a labral tear – a condition frequently caused by trauma.

Testimony of Tom McDermott:

Tom McDermott testified that he is 22 years old and currently works as a booking officer at the Chicago Ridge Police Department. Tom McDermott testified that he starts the Police Academy in September 2013 and will be a police officer by next summer. Tom McDermott testified that on July 20, 2012 he also received a call from Mark LaPore, a union representative. Mr. LaPore offered Tom McDermott the same 2 day job he had offered Petitioner. Tom McDermott advised Mr. LaPore of transportation issues and coordinated with Petitioner to give him a ride to the jobsite. Tom McDermott was not friends with Petitioner and had only met him on one prior occasion when he gave him a ride to a different job site. On the afternoon of July 21, 2012 Tom McDermott was picked up by the Petitioner at his Orland Park home and traveled to the jobsite.

Tom McDermott testified that he arrived at the jobsite with the Petitioner, parked, and contacted Kirk Wessel, a supervisor for Respondent. Tom McDermott testified that he and Petitioner met up with Kirk Wessel and the other supervisor, Rob Stelter. While Petitioner moved his car, Tom McDermott stayed at the jobsite. When Petitioner returned to the jobsite, he was given a bright yellow safety vest and gloves. No other safety training or gear was issued to Tom McDermott either. Tom McDermott testified that he did not remember signing any safety logs but did confirm his signature on all but one page when presented with the log.

Tom McDermott testified that he worked with the Petitioner during the entire job. Tom McDermott testified there first task was to grind down concrete. After doing that for a few hours they were given primer to apply to all the concrete. The concrete was being primed so that a membrane could be installed. The process included using power sprayers in which Tom McDermott and Petitioner would be down on their hands and knees holding the membrane while a chemical was being sprayed over their shoulders causing chemical to splash / spray onto the back of their necks. Tom McDermott testified that after working with the primer for about an hour he started to burn on the back of his neck. Both Petitioner and Tom McDermott testified that this was not a sun burn as it was dark out the majority of the time they worked with the primer. Tom McDermott further described the burn as coming from underneath the skin. Tom McDermott testified that he and Petitioner approached the supervisors on three separate occasions to complain about the burns. On each occasion they were told that the primer does not have anything in it that would cause a burn. Tom McDermott testified that about 3:00-4:00 in the morning Petitioner advised him that he was going to search for a rag to put water on so he would wipe down the back of his neck. Tom McDermott testified that Petitioner walked about 30-40 feet away from him on a bridge. As Petitioner walked towards a bridge, there was a plank covering a hole in the ground. Tom McDermott testified that he watched Petitioner trip on the plank and land on his right side striking his hip, lower back and head. Tom McDermott testified that as Petitioner stood up there was blood coming down his face from his nose and from a cut on his head. Tom McDermott testified that he watched Petitioner use his work issued safety vest to wipe the blood. The vest with all the dried blood was presented and viewed by all parties at the hearing. Tom McDermott testified that after a short time Petitioner stood up and walked past him. Tom McDermott testified that as Petitioner walked by he inquired if he was OK. Tom

McDermott testified that Petitioner walked straight over to one of the two supervisors. Tom McDermott testified that he does not know what Petitioner said to the supervisor but that Petitioner was wiping the blood from his face at the time. Tom McDermott testified that Petitioner next walked past him again stating that he needed to find something to control and wipe the bleeding. Tom McDermott testified that Petitioner came back to the site a short time later with the blood all over his vest and returned to work. Tom McDermott testified that he wrote down all the events of this job within days of the job ending. Tom McDermott testified that he did this because when: significant events such as your skin burning or when you see someone fall and hurt their hip, that's something worth writing down. (Transcript P. 94).

Tom McDermott testified that the burning on his neck continued to get worse and at about 7:00 A.M. he decided he could not handle it anymore. Tom McDermott testified that he and Petitioner went up to the supervisors who again said that the chemical will not burn you and if you wanted to leave that was fine. At that point Tom McDermott testified he could not handle it anymore so he left the area and went to Petitioner's car where he sat with the air conditioning going on full attempting to cool the burns. Tom McDermott testified that Petitioner returned to the car about 10:00 A.M. and asked him to drive home because he was in too much pain. Tom McDermott testified that does not and did not drink any energy drinks prior to or on this job site and did not vomit at any time.

Testimony of Wayne Borg:

Wayne Borg testified that he is a friend and a neighbor of Petitioner. Wayne Borg testified that the Petitioner was in excellent physical shape prior to 7/21/12. Wayne Borg testified that he used to regularly take 15-20 mile bicycle rides with the Petitioner prior to this

accident. Wayne Borg further testified that he would regularly see the Petitioner jogging around the neighborhood prior to 7/21/2012. Wayne Borg further testified that he went on a 15 mile bicycle ride with the Petitioner on the morning of 7/21/12. Wayne Borg testified that he has not taken any bicycle rides or seen Petitioner jogging in the neighborhood since 7/21/12.

Testimony of Robert Stelter:

Robert Stelter testified that he was a supervisor for Respondent on the Metra job. Mr. Stelter remembers the Petitioner from the job. Mr. Stelter denies that anyone could have sustained a burn while working with the chemical primer on the job. Mr. Stelter admits that Petitioner complained once to him about his neck burning from the chemical, but denies that Tom McDermott ever complained. (Transcript P.122). Interestingly however, Mr. Stelter does admit that lots of the people's necks on the Metra Job were red and burned. (Transcript P.122). Mr. Stelter denies that Petitioner ever reported an injury to him or ever seeing him with a bloody nose or bloody vest. Mr. Stelter confirms his mobile number of 414-349-3892 and multiple phone calls post-accident with the Petitioner first on Monday, July 26, 2012 at 2:48 P.M. and at 3:16 P.M. Mr. Stelter claims that there was no conversation in any of the phone calls regarding an accident while working at the Metra site. Mr. Stelter claims all the phone calls were Petitioner calling him looking for work but then admits that is not the protocol of how employees get hired to work at companies like Respondent's. (Transcript 129). When pressed, Mr. Stelter admits during the conversation on 8/3/12 that Petitioner may have complained to him about an on the job injury. (Transcript P. 127).

Testimony of Kirk Wessel:

Kirk Wessel testified that he was a supervisor for Respondent on the Metra job. Mr. Wessel remembers the Petitioner from the job. Mr. Wessel denies that anyone could have sustained a burn while working with the chemical primer on the job. Mr. Wessel denies that Petitioner or Tom McDermott ever complained to him about their necks burning while working. Mr. Wessel denies that Petitioner ever reported an injury to him or ever seeing him with a bloody nose or bloody vest. Mr. Wessel denies ever speaking to Petitioner about an injury on the Metra Job. Then, even though Mr. Wessel denies ever speaking to the Petitioner about an injury, at 4:30 A.M. at the Metra Job he questioned Petitioner about his limp and asked him if he was ok. Next, Mr. Wessel confirms his work mobile number of 414-349-6234 but denies any phone calls with the Petitioner after the job for about 2 months. (Transcript P.148). However, the AT&T records of Mr. Ghezzi confirm otherwise. Specifically, on July 23, 2012 at 12:18 P.M. Mr. Wessel calls Petitioner. Then on July 26, 2012 at 3:17 P.M. Mr. Wessel speaks with Petitioner again and has a 2 minute conversation. Then we hear a longer conversation Kirk Wessel has with the Petitioner that clearly discusses details of the accident. These three calls alone when Kirk Wessel denies contact with Petitioner for two months destroys Mr. Wessel's credibility for any memory of what occurred on this job. This conclusion is further supported by the fact that Kirk Wessel cannot get his story straight about whether or not he saw Tom McDermott throw up. Please see the transcript page 53:

Question:	Were you there when – you told us earlier that it was your understanding that Tom McDermott had thrown up. Did you witness him throwing up.
Answer:	No. I said my understanding was that he drank a lot of energy drinks, which then made him get sick.
Question:	Did you witness him throwing up?
Answer:	Yes, I did; and I took him a bottle of water.

Kirk Wessel testifies to two diametrically opposite answers to the same question. First he says he did not see Tom McDermott throw up and then in the next questions he says he did. Most important – Tom McDermott denies ever drinking any energy drinks or throwing up.

CONCLUSIONS OF LAW

The Arbitrator makes the following findings on the issue of (C):

Did an accident occur out of and in the course and scope of Petitioners employment by the respondent?

Petitioner testified that he began to experience a burning pain in the back of his neck about an hour after starting to work with the chemical primer. The process included using power sprayers in which Petitioner would be down on his hands and knees holding the membrane while chemical primer was being sprayed over his shoulder causing chemical to splash onto the back of his neck. Both Petitioner and Tom McDermott testified that this was not a sun burn as it was dark out the majority of the time they worked with the primer. Petitioner and Tom McDermott testified that they approached the supervisors on three separate occasions to complain about the burns. On each occasion they were told that the primer does not have anything in it that would cause a burn. Petitioner testified that about 3:00-4:00 in the morning he went searching for a rag to put water on so he would wipe down the burn on the back of his neck. Petitioner testified that he walked about 30-40 feet away from Tom McDermott on a bridge in search of a rag. As Petitioner walked there was a plank covering a hole in the ground. Petitioner testified that he tripped on the plank landing on his right side striking his hip, lower back and

head. All medical records are consistent with this rendition of the facts. Tom McDermott testified as an independent occurrence witness. Tom McDermott was not friends nor did he have any relationship with the Petitioner prior this accident. Tom McDermott is as independent as a witness comes. Tom McDermott witnessed Petitioner's trip on the plank and fall on his right side only 30-40 feet away. Tom McDermott witnessed Petitioner's stand with blood pouring from his nose and head. Tom McDermott witnessed as Petitioner use his safety vest to cover his nose and try to control the bleeding. Tom McDermott witnessed Petitioner walk back past him and go straight to the supervisor while holding his nose with his safety vest. There was nothing that Respondent's counsel was able to do with Tom McDermott on cross examination to undermine the consistency or credibility of his testimony.

We also received testimony from Wayne Borg regarding the excellent physical condition of Petitioner on July 21, 2012 before going to work. Wayne Borg further testified that he would regularly see the Petitioner jogging around the neighborhood prior to 7/21/2012. Wayne Borg testified that he took a 15 mile bicycle ride with the Petitioner on the morning of 7/21/12. Wayne Borg testified that he has not taken any bicycle rides or seen Petitioner jogging in the neighborhood since 7/21/12. It would seem logical to conclude that Petitioner would not be working on the Metra site if he had a pre-existing hip injury that caused significant pain. Accordingly, it would seem further logical to conclude that an injury happened on the jobsite if he was riding his bicycle hours before going to the job and now he has not gone bicycle riding or jogged since the accident.

Next we have the testimony of the two supervisors. Rob Stelter claims that Petitioner never told him he was burned on his neck yet openly admits that everyone's neck was red and burned. Next Rob Stelter testified that the 3 calls that Petitioner made to him after the accident

were strictly about Petitioner seeking work and included no discussion on an injury on the Metra site. This is completely inconsistent with the fact that according to Petitioner and Tom McDermott, because the only way to get hired on a Union job is through the Union Steward, in this case Mark LaPore. Furthermore, this is inconsistent with the tape recorded phone call with Rob Stelter sometime in August 2012 where Petitioner is again asking him for help. Kirk Wessel claims that Petitioner never told him he was burned on his neck or fell injuring his hip / lower back yet he admits to asking Petitioner about 4:30 A.M. why he is limping and if he was OK. Kirk Wessel does admit contrary to Rob Stelter that people were complaining of their necks burning. (Transcript P.150). Next Kirk Wessel denies talking to Petitioner for two months after the accident yet he called him on 7/23/12 – the next day. According to Petitioner, Mr. Wessel called him, they spoke for 2 minutes, and he asked how he was doing. They then spoke again on July 26, 2012 and in August 2012. This is confirmed by the Petitioner's AT&T bill and the tape recording we heard at trial. Kirk Wessel's claims are completely inconsistent with Petitioner's phone bill which was admitted into evidence proving one incoming phone call from Mr. Wessel to Petitioner and two other calls with Mr. Wessel from Petitioner's phone. Furthermore, this is inconsistent with the tape recorded phone call with Kirk Wessel sometime in August 2012 where Petitioner is again asking him for help. Based on this evidence it is more probably than not the Petitioner sustained an accident in the course and scope of his employment on 07-21-12 and 07-22-12 while working for the Respondent on the Metra jobsite.

The Arbitrator makes the following findings on the issue of (F):

Is Petitioner's present condition of ill-being causally related to the injury?

The medical records from Dr. Oliveri and Dr. Domb corroborate that the Petitioner sustained a hip injury and chemical burns to his neck while working for Respondent on 07-21-12 and 07-22-12. Respondent presented no medical evidence to refute or challenge the opinion of Dr. Oliveri that the chemical burn and the hip / lower back injury is causally related to the injury while working for Metra. Dr. Oliveri testified that the burn he treated on the back of Petitioner's neck on 07-22-13 was a fresh burn based on the fact that it was oozing and blistered. In addition, Petitioner was in great physical shape up until the time he left for the Metra job on 07-21-12. Petitioner testified along with Wayne Borg that they used to regularly to on 15-20 mile rides together and that they went on a 15 mile ride on the morning of 07-21-12. Petitioner testified that he used to jog on average of 20 miles / week. Petitioner testified that he has not gone bicycle riding or jogging since this accident. Wayne Borg testified that he used to see Petitioner regularly jogging around the neighborhood. Wayne Borg testified that he has not gone bike riding or seen the Petitioner jogging around the neighborhood since July 21, 2012. Based on the medical entered into evidence, there can be no dispute to this fact. Respondent has offered no evidence to provide an alternative explanation of the cause of injury.

The Arbitrator makes the following findings on the issue of (E):

Was timely notice of the accident given to the respondent of this injury?

Petitioner testified that as soon as he fell, he stood up, walked back past Tom McDermott and straight to either Rob Stelter or Kirk Wessel. This was witnessed by Tom McDermott – a fact that was not successfully challenged on cross examination. That is the first notice of

accident. Then, at around 7:00 A.M., Tom McDermott and Petitioner approached one of the supervisor's, Tom McDermott testified that he listened as the Petitioner advised the supervisor of the injury – again. That is the second notice of accident. Then on 7/23/12 Kirk Wessel calls Petitioner. Petitioner testified that he called to see how he was doing following his fall. Kirk Wessel has no other explanation for the call. That is the third notice of accident. Next, Rob Stelter confirms his mobile number of 414-349-3892 and four phone calls post-accident with the Petitioner. The first call on Monday, July 26, 2012 at 2:48 P.M. The second call on July 26, 2012 at 3:16 P.M. The third on August 3, 2012 at 9:14 A.M.. Mr. Stelter claims that in all of these calls, there was no conversation regarding an accident while working at the Metra site. Mr. Stelter claims all the phone calls were Petitioner calling him looking for work. This claim of Mr. Stelter is very convenient based on the circumstances. First Mr. Stelter denies that Petitioner or Tom McDermott reported that their necks were burning after using the priming chemical but then admits that everyone else had burned necks. That calls his credibility into question. Second, when confronted with the post-accident phone calls, Mr. Stelter would have us believe that all conversations were about Petitioner seeking work. The problem with this claim is the fact that the fourth call from August 2012 that was heard at trial clearly discusses and injury while working. In addition, according to Tom McDermott and Petitioner, the protocol is clear. In order to get work on a union job you get hired by a union representative – not the employer. That protocol is exactly what happened in this situation as both Petitioner and Tom McDermott were hired by Mark LaPore from the union. Accordingly, any claim by Rob Stelter that the phone calls from the Petitioner were to seek work seems less unlikely. These are the fourth, fifth, sixth, and seventh notice of accident. Finally, Tom McDermott saw the Petitioner go up to one of these supervisors right after he fell while he was controlling his bleeding with his work

vest. Clearly a presentation of this nature would include the reasoning of the blood. That is the eighth notice of accident. Based on all these contacts, there can be no valid claim that the Respondent did not receive valid timely notice of accident.

The Arbitrator makes the following findings on the issue of (G):

What were petitioner's earnings during the year preceding the accident?

Petitioner was hired to work a two-day job on the weekend. As a result, he is a "seasonal employee" under the Act and a not full-time. Sylvester v. Industrial Commission 197 Ill.2d 225 (2001). As a result, his average weekly wage would be calculated by multiplying the hours he worked that week (17.5) by his rate of pay $ 36.20, with the understanding that overtime at the straight time rate is included, then dividing that sum by the number of weeks worked (1). The above analysis results in an AWW of $ 633.50.

The Arbitrator makes the following findings on the issue of (J):

Were the medical services that were provided to the petitioner reasonable and necessary?

The Petitioner's first treatment was within 12 hours of the accident with Dr. John Oliveri. Dr. Oliveri is board certified in Internal Medicine. At all treatment dates (07-22-12, 07-25-12, 09-25-12, and 10-04-12) Dr. Oliveri was a licensed medical doctor in good standing in the State of Illinois. While it is true that Dr. Oliveri had some licensure issues that occurred in February 2013 that were discussed at his deposition, that has nothing to do and is irrelevant to the treatment dates and the care provided in 2012. Dr. Oliveri's records lay out the same consistent

history as his testimony, the testimony of Tom McDermott, the physical shape / disability testimony of Wayne Borg. Dr. Oliveri's charges for the four visits is $710.00 and there is no evidence that this is not reasonable and necessary.

The second doctor the Petitioner saw was from Hinsdale Orthopedics. This visit was authorized by the Respondent. Petitioner saw Dr. Benjamin Domb on November 19, 2012. Dr. Domb's records report the same consistent history of an accident that we have from all other evidence. Dr. Domb diagnosed the Petitioner with a possible labral tear and administered and hip injection. The Petitioner testified that injection helped for a few weeks which confirms the diagnosis. Dr. Domb took the Petitioner off of work, ordered a lumbar MRI, and referred Petitioner to Dr. Lorenz who he saw on December 17, 2012. Dr. Lorenz's records also record the same consistent history of a burn injury and fall over a plank while working in July 2012. The total bill from Hinsdale Orthopedics at this point is $3,824.00 and there is no evidence that this is not reasonable and necessary.

The Arbitrator makes the following findings on the issue of (K):

What amount of compensation is due for Temporary Total Disability?

The parties stipulated to the dates of TTD of 11-19-12 to 04-30-13 but Respondent contested liability. The evidence reveals that the Respondent authorized the Petitioner to see Dr. Domb on 11-19-12. It was at this visit that Dr. Domb took the Petitioner off of work. Petitioner has not worked since Dr. Domb took him off. Respondent presented no evidence that the Petitioner could work during this time. Respondent presented no evidence Petitioner's lost time

is not compensable. Accordingly Petitioner is due 23 2/7 weeks of back TTD and TTD going forward as he continues to treat for these injuries.